

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Benjamin Jackson		2. DATE OF DEATH MONTH DAY YEAR December 15, 1986		2b. HOUR 9:10 AM	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR Dec. 28, 1907	
6. AGE (IN YEARS LAST BIRTHDAY) 78		7. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City		8. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Georgia		10. CITIZEN OF WHAT COUNTRY? USA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN A FACILITY, GIVE STREET ADDRESS) South Balto. General	
12. CITY OR TOWN OF DEATH Balto		13. USUAL OCCUPATION (TYPE WORK FOR MOST OF WORKING LIFE) Carpenter		14. KIND OF BUSINESS OR INDUSTRY Retired	
15. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 15a. STATE MD 15b. COUNTY AA 15c. CITY OR TOWN Brooklyn		16. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		17. STREET ADDRESS, ZIP CODE Balto. Md 21225	
18. FATHER'S NAME FIRST Hosey MIDDLE Jackson LAST Jackson		19. MOTHER'S MAIDEN NAME FIRST Unknown MIDDLE Unknown LAST Unknown		20. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) Yes (GIVE WAR OR DATES) IWW II	
21. SOCIAL SECURITY NO. 204-07-5027		22. INFORMANT NAME Lessie Jackson ADDRESS Balto. Md 21225		23. DATE OF OPERATION 11/14/86	
24. CONDITION FOR WHICH OPERATION WAS PERFORMED Cardio Respiratory arrest		25. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		26. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
27. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardio Respiratory arrest DUE TO, OR AS A CONSEQUENCE OF, (b) ASAD DUE TO, OR AS A CONSEQUENCE OF, (c) ASAD		28. DATE OF OPERATION 11/14/86		29. CONDITION FOR WHICH OPERATION WAS PERFORMED Cardio Respiratory arrest	
30. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, INDENTIFY MEDICAL SITUATION) NO		31. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		32. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 28, PART I OR PART 2) 12/14/86	
33. INJURY OCCURRED WHERE <input type="checkbox"/> AT HOME <input type="checkbox"/> NOT WHERE <input type="checkbox"/>		34. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 11/14/86		35. LOCATION STREET CITY OR TOWN COUNTY STATE 12/14/86	
36. I certify that (I) this hospital attended the deceased from 11/14/86 to 12/14/86 , that (I) (we) lost saw the deceased alive on 11/14/86 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If deceased did not view the body after death.		37. SIGNATURE George B. Ramire DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		38. DATE SIGNED 12/16/86	
39. REGISTRAR'S NAME (TYPE OR PRINT) George B. Ramire		40. ADDRESS 7845 Oakwood Rd 5105 Glen Burnie Maryland 2106		41. DATE REC'D. BY REGISTRAR DEC 16 1986	
42. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) Burial		43. DATE 12/20/86		44. NAME OF CEMETERY OR CREMATORY MD Veterans	
45. FUNERAL DIRECTOR NAME Furnell B. Odon - 1631		46. DATE REC'D. BY REGISTRAR DEC 16 1986		47. REGISTRAR'S SIGNATURE W. J. ...	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

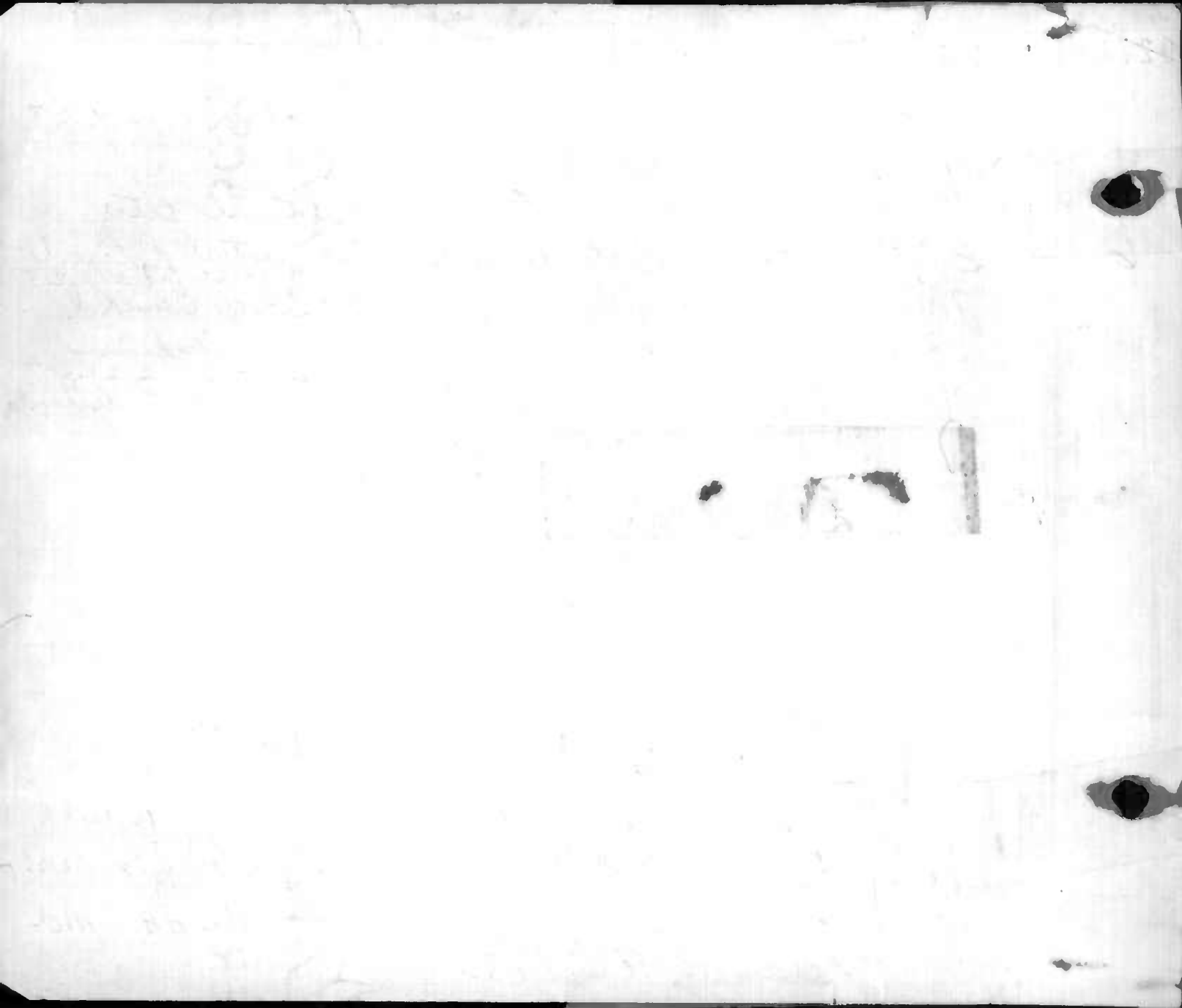
TO HOSPITAL CONSULTING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after cause of death may be ascertained by the attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Their please remove certificates, Pages 1 and 2, should be filed within 72 hours after death in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified on-site.

DHMF 16 57M 4/83

18,401,4



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR2. DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Corn

Jackson

3. DATE OF DEATH

MONTH

DAY

YEAR

12/25/86

2b. HOUR

10.33 PM

3. SEX

Female

4. RACE

Black

5. DATE OF BIRTH

11/16/1900

6. AGE (IN YEARS LAST BIRTHDAY)

86

IF UNDER 1 YEAR

MONTHS

DAYS

IF UNDER 24 HRS

HOURS

MIN.

7a. BIRTHPLACE
(COUNTRY)

(STATE OR FOREIGN)

7b. CITIZEN OF WHAT COUNTRY?

U.S.A

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore, Md. (City)

10. CITY OR TOWN OF DEATH

Baltimore

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

Liberty Medical Center

12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)

retired

12b. KIND OF BUSINESS OR INDUSTRY

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13b. STATE

13c. COUNTY

13d. CITY OR TOWN

13e. INSIDE CITY LIMITS?
YES ☒ NO ☐

13f. STREET ADDRESS / ZIP CODE

7601 2nd Mall Rd Baltimore, Md. 21215

14. FATHER'S NAME
FIRST

MIDDLE

LAST

15. MOTHER'S MAIDEN NAME
FIRST

MIDDLE

LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)

No

16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)

816-03-0545

17. INFORMANT

2nd Mall Nursing Home - 7601 2nd Mall Rd Baltimore, Md. 21215

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

Cardio respiratory arrest

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause lost.

(b) Unknown

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION

12/10/86

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

Gangrene Left Foot

20a. AUTOPSY?

YES ☐ NO ☒20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 1986

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)

21d. INJURY OCCURRED
WHILE ☐ NOT WHILE ☐
AT WORK AT WORK21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)21f. LOCATION
STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from 12/8/86 to 12/25/86, that (I) (we) lost
saw the deceased alive on 12/25/86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

Z.N. Lahiji

DEGREE

ATTENDING
PHYSICIAN ☐MEDICAL
DIRECTOR ☐STAFF
PHYSICIAN ☒

22c. DATE SIGNED

12/25/86

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

Z.N. LAHIJI

22e. ADDRESS

Liberty Medical Center
Baltimore, Md. 21215

23a. BURIAL, CREMATION, REMOVAL

Burial

23b. DATE

12/31/86

23c. NAME OF CEMETERY OR CREMATORY

Mt. Auburn Cnd.

23d. LOCATION
CITY OR TOWN

Baltimore

COUNTY

Md.

24. FUNERAL DIRECTOR

NAME

ADDRESS

Garcia P. Carroll 1712-14 W. North Ave

25a. DATE REC'D. BY REGISTRAR

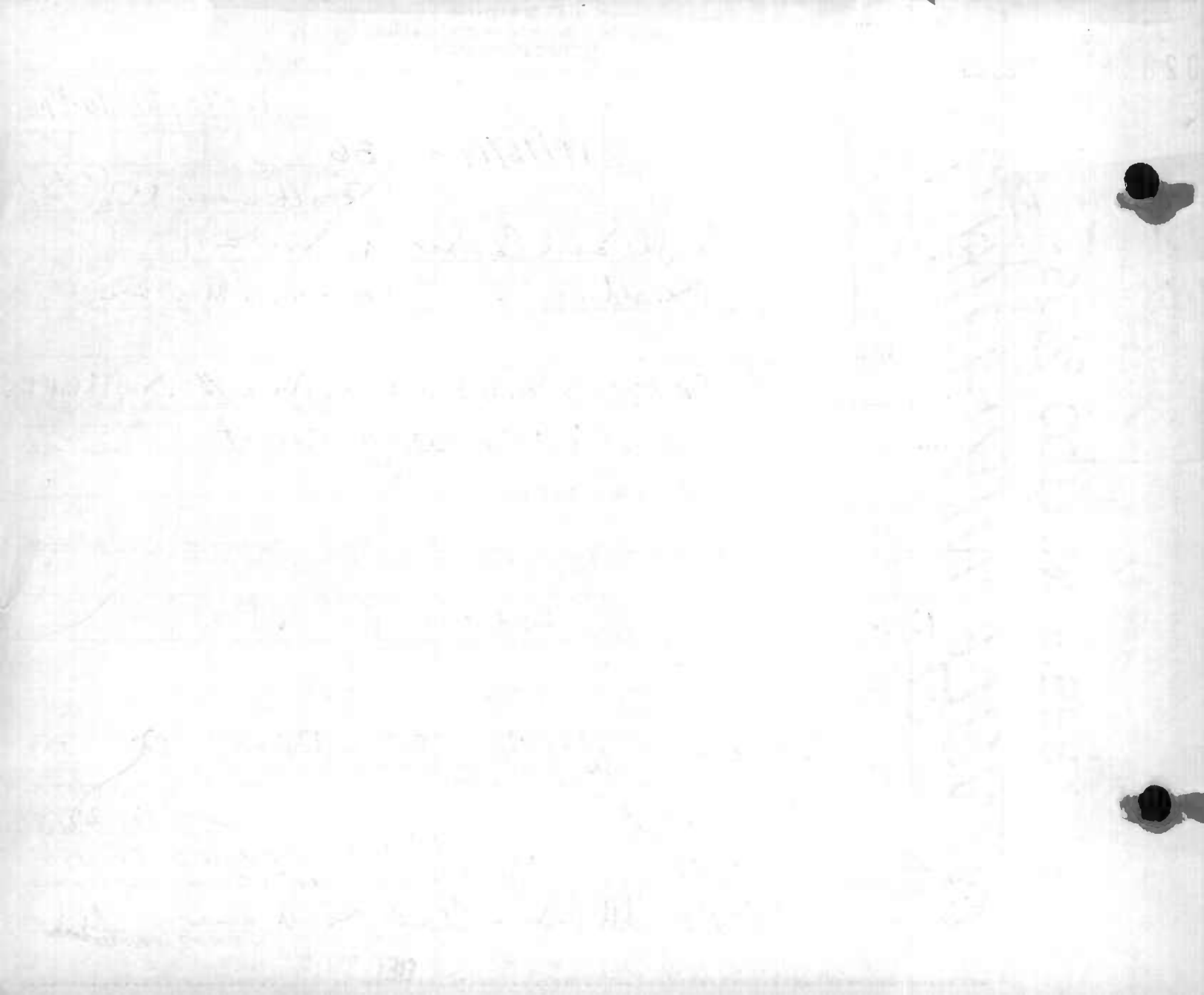
DEC 29 1986

25b. REGISTRAR'S SIGNATURE

[Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and appropriately filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



028401 DEC 1986

STATE OF MARYLAND
G-624, 2/4/87
REGISTRAR Gbj. Med. Ex.DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
Edith						Jackson		XX		12		20		1986		M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		2d. HOUR	
F	B	4 7 69		17 YRS.						12		20		1986		5:40 p.m.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH								MD	
Maryland		USA		WIDOWED		DIVORCED		Baltimore City,									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Baltimore		Mercy Hospital		Unemployed													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
MD.		BALTO.		BALTO		YES		3106 Four Season Ct									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
Bruce		Carrie		NO				Margelene Jones		3106 Four Season Ct							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
				Cardiac arrhythmia													
				Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.		(b) Eclampsia											
						(c) Full term pregnancy											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?													
12/4/86		Cesarean section		YES XX NO													
21a. EXTERNAL CAUSE WAS		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)													
UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		HOUR A.M. MONTH DAY YEAR															
		P.M. 19															
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION													
WHILE AT WORK NOT WHILE AT WORK				STREET		CITY OR TOWN		COUNTY		STATE							
22a. I certify that I took charge of the remains described above, held an		Autopsy XX		Inspection		Inquiry		and in my opinion									
death resulted from:		Natural causes X		Accident		Suicide		Homicide		Undetermined manner							
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED													
William M. Zane		M.D. Assistant		12-21-86													
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS															
William M. Zane, M.D.		111 Penn St., Balto., Md.		21201													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE							
Burial		12-23-86		Mt Auburn		Balto.				MD.							
24. FUNERAL DIRECTOR		NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
Wm. C. Brown		1206 W. North Ave				24 Dec											

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN SPACE IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER. THE MEDICAL EXAMINER'S SIGNATURE AND SEAL ARE REQUIRED. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84

25M

DHMH - 17
(VR A15 ME (5))

2000 10465

2000 10465



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DHMH - 16 60M 7/B4
(VRA 15, 4)TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept until 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JUNOES L. JACKSON					2a. DATE OF DEATH MONTH DAY YEAR 12-1-86		2b. HOUR M		
3. SEX MALE		4. RACE B		5. DATE OF BIRTH MONTH DAY YEAR 1 29 30		6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS		7. IF UNDER 1 YEAR IF UNDER 72 HRS MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTO.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 564 RADNOR AVE.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) B.C. Water Dept		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) MD		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 564 RADNOR AVE 21212	
14. FATHER'S NAME FIRST MIDDLE LAST Herman Williams		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah R. Jackson							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 247566262		17. INFORMANT ADDRESS GRACE JACKSON 564 RADNOR AVE					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic esophageal carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>June 20</u> , 19 <u>86</u> , to <u>December 1</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>Nov. 21</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Paul Chang, M.D.</u>		DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/1/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Paul Chang, M.D.</u>		22e. ADDRESS <u>St. Joseph Hospital, Towson, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE 12-6-86		23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cem.</u>		23d. LOCATION CITY OR TOWN <u>Pikesville</u>		STATE <u>MD</u>	
24. FUNERAL DIRECTOR NAME <u>MARCH F/H</u>				ADDRESS <u>1101 E. NORTH AVE.</u>		25a. DATE REC'D. BY REGISTRAR DEC 5 1986		25b. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon transfer pages 1 and 2 and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/B4
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 3 4 5 4 0

REG. NO.

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE Amelia LAST JACKSON			2a. DATE OF DEATH MONTH DAY YEAR 12/1/86		2b. HOUR 12:45 PM
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 10/22/08	6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lutheen Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nurse	12b. KIND OF BUSINESS OR INDUSTRY Nursing Home	
13a. STATE Md			13b. CITY OR TOWN BALTIMORE	13c. STREET ADDRESS / ZIP CODE 2308 Wichita Ave 021215	
14. FATHER'S NAME FIRST Edward MIDDLE BROWN LAST		15. MOTHER'S MAIDEN NAME FIRST Amanda MIDDLE BERRY LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 081054214		17. INFORMANT Brenda Lee - Columbia, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCUR</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 1a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>10/2</u> , 19 <u>86</u> , to <u>12/1</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>12/1</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE MARILDAIS		DEGREE MD		22c. DATE SIGNED 12/1/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARILDAIS		22e. ADDRESS 9057 BALTIMORE PILE CUMD 2104			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 12-4-86	23c. NAME OF CEMETERY OR CREMATORY White Rock Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Lynchville Carroll Md.	
24. FUNERAL DIRECTOR HARRY W. HIGHT		ADDRESS Lynchville, Md.		25a. DATE REC'D. BY REGISTRAR DEC 3 1986	
25b. REGISTRAR'S SIGNATURE Julia Gordon-Randall					

MEDICAL CERTIFICATION

BP

28853 JAN -20

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 3 4 5 4 7

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST MILDRED	MIDDLE	LAST JACKSON	2a. DATE OF DEATH		MONTH DECEMBER	DAY 25,	YEAR 1986	2b. HOUR P 5:30	M	
3. SEX Female		4. RACE Black		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY				MD.		
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE MD				13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1713 E. 29th Street 21218		
14. FATHER'S NAME FIRST Andrew				MIDDLE		LAST Johnston		15. MOTHER'S MAIDEN NAME FIRST Lillie		MIDDLE Parham		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-05-3685		17. INFORMANT ADDRESS Eddie Jackson 1713 E. 29th Street						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 minutes</u>		
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Sepsis</u>										1 month		
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diabetes mellitus / Vascular Insufficiency</u>										years		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Renal Failure, anemia, hypercoagulable state</u>												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>11/20</u> , 19 <u>86</u> , to <u>12/25</u> , 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>12/25</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>Steven D. Datorre MD</u>						DEGREE MD			22c. DATE SIGNED 12/25/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Steven D. Datorre MD						22e. ADDRESS JHH, 600 N. Wolfe St. Balt MD.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 12/30/86		23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		23d. LOCATION CITY OR TOWN Baltimore		STATE MD		
24. FUNERAL DIRECTOR NAME March Funeral Home						ADDRESS 1101 E. North Avenue		25a. DATE REC'D BY REGISTRAR DEC 30 1986		25b. REGISTRAR'S SIGNATURE Julia Benson-Randall		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation or other disposition. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

ALL INFORMATION CONTAINED
HEREIN IS UNCLASSIFIED
DATE 12-18-04 BY 60320

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FOR OFFICIAL USE ONLY

1. PURPOSE AND SCOPE

2. BACKGROUND

3. OBJECTIVES

4. METHODOLOGY

5. RESULTS

6. CONCLUSIONS

7. REFERENCES

8. APPENDICES

9. GLOSSARY

10. ACRONYMS

11. DISTRIBUTION

12. APPROVALS

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the official, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove your stamp from page 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition of the body.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic cause of death, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) MILDRED (D) JACKSON						2a. DATE OF DEATH MONTH DAY YEAR 12/1/86			2b. HOUR 9:10 PM		
3. SEX F		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 8 13 05		6. AGE (IN YEARS LAST BIRTHDAY) 8 YRS			IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) U.S.A.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CITY MD.					
10. CITY OR TOWN OF DEATH BALTO. CITY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LIBERTY MEDICAL CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) UNK			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE MD				13c. CITY OR TOWN BALTO		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4125 Norfolk Ave. 21216			
14. FATHER'S NAME FIRST MIDDLE LAST UNK				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lucy Sparks							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 7		17. INFORMANT ADDRESS GWENDOLYN Saunders 2826 Ellicott Dr					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF (b) CONGESTIVE HT. FAILURE + SEPSIS DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 11/25/86											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NO! WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 12/1, 1986, to 12/1, 1986, that (I) (we) lost saw the deceased alive on 12/1, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE ROBERTO FRANCISCO						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 12/1/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERTO FRANCISCO						22e. ADDRESS LIBERTY MEDICAL CENTER					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 12-5-86		23c. NAME OF CEMETERY OR CREMATORY MT AUBURN		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD			
24. FUNERAL DIRECTOR NAME March F/A 101 E. North Ave						25a. DATE REC'D. BY REGISTRAR DEC 2 1986		25b. REGISTRAR'S SIGNATURE Julia Davidson-Rodgers			

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Catherine Bell Jacobs			2a. DATE OF DEATH MONTH DAY YEAR 12-7-86			2b. HOUR 4:30 PM				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 2-12-04		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Va.		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Baltimore General Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Homemaker		
13a. STATE MD.			13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST Clarence ----- Rutherford			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown			13e. STREET ADDRESS 21230 Balto. Md. 1716 Clarkson Street				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 220-74-8235		17. INFORMANT Chart Joan E. Goad				ADDRESS Pasadena, Md. 21122 1121 Whoz Dr.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Pulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Pulmonary Embolism DUE TO, OR AS A CONSEQUENCE OF (c) Hypotension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Aspiration Pneumonia										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT HOME			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, PARK, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 12-4-1986 to 12-7-1986 that (I) (we) last saw the deceased alive on 12-7-1986 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) see the body after death.										
22b. SIGNATURE Dr. Alexander Bogdaschewski						DEGREE M.D.		22c. DATE SIGNED 12-7-86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Alexander Bogdaschewski						22e. ADDRESS 3001 S. Hanover Street				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/10/86		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie, A.A. Co. Md.			
24. FUNERAL DIRECTOR NAME Balto. Md. 21230 ADDRESS McCully Funeral Home, 130 E. Fort Ave.						25a. DATE REC'D. BY REGISTRAR DEC 8 1986		25b. REGISTRAR'S SIGNATURE Julia Decker-Randall		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove embossers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be notified at once.

BP _____

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(VIA 15, 4)

10-17-1983

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the undersigned pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or interment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8034550

FOR
1. STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JULIUS L. JACOBS, Sr.			2a. DATE OF DEATH MONTH DAY YEAR 12/01/86			2b. HOUR 12:45 PM			
3. SEX M		4. RACE B		5. DATE OF BIRTH MONTH DAY YEAR 06/10/17		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO, CITY MD.			
10. CITY OR TOWN OF DEATH BALTO.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINIA HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Board of education	
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4013 Fairview Ave. 21216	
14. FATHER'S NAME FIRST MIDDLE LAST Julius L. Jacobs				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Hunt					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1945/1945		17. INFORMANT Elizabeth Jacobs		ADDRESS 4013 Fairview Ave. Balto.		21216	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF (b) 3 Hemispheric CVA DUE TO, OR AS A CONSEQUENCE OF (c) massive GI Bleed								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Peripheral Vascular Dz									
19a. DATE OF OPERATION N/A		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 07/27 , 19 86 , to 12/01 , 19 86 , that (I) (we) lost saw the deceased alive on 12/01 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Carole A. Freeland, MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12/01/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CAROLE A. FREELAND				22e. ADDRESS SINIA HSP. 9 BALTO Belvedere @ Greenspring's BALTO, MD. 21215					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-4-86		23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland			
24. FUNERAL DIRECTOR NAME Bailey Funeral Home 1348 N. Calhoun St. 21217				25a. DATE REC'D. BY REGISTRAR DEC 9 1986		25b. REGISTRAR'S SIGNATURE [Signature]			



028306 DEC 29 1986

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, an other traumatic event, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8634551	
1. DECEASED NAME (TYPE OR PRINT) CONA JAMES					2a. DATE OF DEATH MONTH DAY YEAR 12-17-86			2b. HOUR 1A M			
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 12 18 94		6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Key Circle N. Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 12a. STATE Maryland 12b. COUNTY				13. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Key Circle N.H. 21217			
14. FATHER'S NAME George MIDDLE Mallory LAST				15. MOTHER'S MAIDEN NAME Sarah FIRST MIDDLE Mallory LAST							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT Chad				ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) A.S.C.V.D., E.C.H.F. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 10-17 , 19 86 , to 12-17 , 19 86 , that (I) (we) lost saw the deceased alive on 12-17 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE G. Shah				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. G. SHAH				22e. ADDRESS 2105, N. Charles St BALTIMORE 21208							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal			23b. DATE 12/17/86		23c. NAME OF CEMETERY OR CREMATORY Bethany Church Cent.			23d. LOCATION CITY OR TOWN COUNTY STATE Mt. Pelee Virginia			
24. FUNERAL DIRECTOR NAME E. L. Phillips ADDRESS 1721-27th N. Mount St.						25a. DATE REC'D. BY REGISTRAR DEC. 22 1986		25b. REGISTRAR'S SIGNATURE Julia Davidson-Baker			

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029637 JAN 18 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

ARTHUR

Levi

JENKINS

2a. DATE KNOWN OF DEATH ESTIMATED ☒ MONTH DAY YEAR 2b. HOUR
12 21 19 86

3. SEX

Male

4. RACE

Black

5. DATE OF BIRTH

10/26/41

6. AGE (IN YEARS)

45

IF UNDER 1 YR.

IF UNDER 24 HRS.

2c. DATE PRONOUNCED DEAD
12 21 19 86

2d. HOUR
6:50 PM

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
S.C.

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED ☒ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore City

MD.

10. CITY OR TOWN OF DEATH

Baltimore

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION

24 N. Fulton Ave.

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Md.

13b. COUNTY

13c. CITY OR TOWN

Baltimore

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS

24 S. Fulton Ave. 21223

14. FATHER'S NAME

FIRST

Jacob

MIDDLE

B. Jenkins

LAST

15. MOTHER'S MAIDEN NAME

FIRST

Mamie

MIDDLE

Bell

LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)

NO

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.

251-64-1444

17. INFORMANT

ADDRESS

Albert Jenkins 2615 3rd St. D.C. 20002

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

(b) _____

DUE TO, OR AS A CONSEQUENCE OF

(c) _____

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

Diabetes mellitus

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS

UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐
AT WORK AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION

STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐.

ACTUAL SIGNATURE

TITLE (SPECIFY)

Assistant

MEDICAL EXAMINER

DATE SIGNED 12-24-86

EXAMINER'S NAME (TYPE OR PRINT)

Dennis F. Smyth, M.D.

ADDRESS 111 Penn St., Balto., MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b. DATE

1/5/87

23c. NAME OF CEMETERY OR CREMATORY

Mt. Zion Cem.

23d. LOCATION

Lansdowns

COUNTY

A.A.

STATE

Md.

24. FUNERAL DIRECTOR

NAME

Chas. A. Rice FSPA

ADDRESS

1300 Eutaw Place

25a. DATE REC'D. BY REGISTRAR

JAN 13 1987

25b. REGISTRAR'S SIGNATURE

Julia Gordon-Randall

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL. ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

SEP 19 1968

ONE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: Item 91 is marked on item 18 shows any injury, or other traumatic event, if the medical examiner has been notified and examined the body.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) PAUL J. JENKINS SR.				2a. DATE OF DEATH MONTH DAY YEAR DEC 15 1986			
3. SEX Male				2b. HOUR 5:00 PM			
4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR September 26, 1924		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Car Man		12b. KIND OF BUSINESS OR INDUSTRY B. & O. Railroad	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Catonsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Henry Joseph Jenkins		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Landora Compton		13e. STREET ADDRESS / ZIP CODE 501 Academy Road 21228			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II 215-14-9409		17. INFORMANT ADDRESS Edna M. Jenkins Same as # 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) ASPIRATION OF VOMITUS. DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a CARDIAC FAILURE ISCHEMIC HEART DISEASE 2 PREVIOUS CARDIAC ARRESTS							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE M. Shortall				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. SHORTALL				22e. ADDRESS 87 Agnes Road 900 Cedar Ave Baltimore Md 21224			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/18/86		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park		23d. LOCATION CITY OR TOWN COUNTY STATE Woodlawn Maryland	
24. FUNERAL DIRECTOR Leroy M. & Russell C. Witzke 1630 Edmondson Avenue, Catonsville, MD. 21228				25a. DATE REC'D. BY REGISTRAR DEC 18 1986		25b. REGISTRAR'S SIGNATURE Julia Gordon-Randall	

00000000000000000000000000000000

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6

3 4 5 5 4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>William R. Jenkins</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>12 02 86</i>			2b. HOUR <i>2:30 PM</i>			
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>04 29 1923</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>63</i> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.			
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Mercy Hosp. Balto. Md.</i>				12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) <i>Ret. Police</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Balto. City</i>	
13a. STATE <i>Maryland</i>			13b. COUNTY <i>Baltimore</i>		13c. CITY OR TOWN <i>Baltimore</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>William L. Jenkins</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Ida E. Montgomery</i>			13e. STREET ADDRESS / ZIP CODE <i>623 E. Fort Ave, Balto, Md. 21230</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>Yes</i>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>W.W.2</i>		17. INFORMANT ADDRESS <i>Mrs. Laura E. Jenkins, Same as above</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Septic shock</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>metastatic carcinoma</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <i>11/17</i> 19 <i>86</i> , to <i>12/02</i> 19 <i>86</i> , that (I) (we) lost saw the deceased alive on <i>12/02</i> 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Keith Friend</i>			DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STATE PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Keith Friend</i>			22e. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>12/5/86</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Glen Haven Mem. Pk.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Glen Burnie, A.A. Co Md.</i>		
24. FUNERAL DIRECTOR NAME ADDRESS <i>McCully Funeral Home, Balto. Md. 21230</i>			25a. DATE REC'D. BY REGISTRAR (SEAL REGISTRAR'S SIGNATURE) <i>DEC 4 1986</i>						

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

DHMH - 16 60M 7/84
(VRA 15, 4)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) HATTIE				2a. DATE OF DEATH MONTH NOVEMBER DAY 27 YEAR 1986			
3. SEX F				2b. HOUR 12:06am			
4. RACE Black		5. DATE OF BIRTH MONTH 3 DAY 17 YEAR 1920		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.		7. IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Houswife		12b. KIND OF BUSINESS OR INDUSTRY *****	
13a. STATE Maryland		13b. COUNTY *****		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST Alexander MIDDLE Gordan LAST Gordan		15. MOTHER'S MAIDEN NAME FIRST Laura MIDDLE Brown LAST Brown		16. STREET ADDRESS / ZIP CODE 1631 Division St 21217			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 217-22-7587		17. INFORMANT ADDRESS Martha Watson P. O. Box 23 Kister W. Va 25628			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thrombotic Thrombocytopenia Purpura DUE TO, OR AS A CONSEQUENCE OF (b) Renal Failure DUE TO, OR AS A CONSEQUENCE OF (c) Pneumonia							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from November 5, 1986 to November 27, 1986 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on November 27, 1986 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (not) view the body after death.							
22b. SIGNATURE Chu-Huang Chen		DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 11-27-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHU-HUANG CHEN MD		22e. ADDRESS c/o Maryland General Hospital					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/30/86		23c. NAME OF CEMETERY OR CREMATORY New Store Ch Cem.,		23d. LOCATION CITY OR TOWN Buckingham Co., Va., COUNTY VA. STATE VA.	
24. FUNERAL DIRECTOR NAME Blond-Reid Funeral Home Farmvill, Va 23901		25. DATE REC'D BY REGISTRAR DEC 04 1986					

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return page 2 to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trauma, then the medical examiner must be notified at once.

FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) William M Jessup, Sr.			2a. DATE OF DEATH MONTH DAY YEAR 12 19 86			2b. HOUR 11:30 AM	
3. SEX male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 2 7 02		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va.		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore City		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University of Maryland Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retired	
12b. KIND OF BUSINESS OR INDUSTRY Maintenance							
13a. STATE MD		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 701 W. Arlington Ave 21217							
14. FATHER'S NAME FIRST MIDDLE LAST Leroy Jessup				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unkn			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-09-5902		17. INFORMANT ADDRESS William Jessup, Jr 1904 Chelsea Terr.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO, OR AS A CONSEQUENCE OF: (b) Cerebral hemorrhage DUE TO, OR AS A CONSEQUENCE OF: (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day 2 weeks
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 10/31/86		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 10/31/86, 19 86, to 12/14/86, 19 86, that (I) (we) last saw the deceased alive on 12/14/86, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Steven J. Kiffner				DEGREE MD		22c. DATE SIGNED 12/14/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Steven J. Kiffner				22e. ADDRESS Univ of MD Hospital 22 S Green Street			
23a. BURIAL, CREMATION, REMOVAL SPECIFY Burial		23b. DATE 12/19/86		23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.	
24. FUNERAL DIRECTOR NAME Wm C March F/H West				ADDRESS 4300 Wabash Ave.		25a. DATE REC'D. BY REGISTRAR DEC 19 1986	
				25b. REGISTRAR'S SIGNATURE Julia Jordan-Rodney			



028461 DEC 30 1986

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ROBERT L. JIMMERSON			2a. DATE OF DEATH MONTH DAY YEAR 12 27 86		2b. HOUR 3:20 PM
3. SEX M	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR 09 18 46		6. AGE (IN YEARS LAST BIRTHDAY) 40 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Florida	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CITY MD.	
10. CITY OR TOWN OF DEATH Balto.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSP. OF BALTIMORE		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Disabled		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE md.			13b. COUNTY	13c. CITY OR TOWN Balto.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST unknown			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EVA Jimmerson		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 212-46-9791		17. INFORMANT ADDRESS William Pierson 1003 Harlem Ave.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MINUTES
DUE TO, OR AS A CONSEQUENCE OF (b) SEPSIS, PNEUMONIA		
DUE TO, OR AS A CONSEQUENCE OF (c) CHRONIC RENAL FAILURE		

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 12-26 , 19 86 , to 12-27 , 19 86 , that (I) (we) last saw the deceased alive on 12-27 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Charles A. Palo		DEGREE M.D.		22c. DATE SIGNED 12-27-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHARLES A. PALO M.D.		22e. ADDRESS C/O SINAI HOSP. OF BALTIMORE BELVEDERE AT GREENSPRING, 21215 MD			

23a. BURIAL, CREMATION, REMOVAL (BY) Burial	23b. DATE 12-30-86	23c. NAME OF CEMETERY OR CREMATORY Eastview Mem. Pk.	23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.
24. FUNERAL DIRECTOR NAME Calvin B. Scruggs		25a. DATE REC'D. BY REGISTRAR DEC 29 1986	25b. REGISTRAR'S SIGNATURE John Deaton-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

BP

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
- REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Adelaide H. Johnson			2a. DATE OF DEATH MONTH DAY YEAR 12 22 86 2b. HOUR 9:15 A.M.		
3. SEX F	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR July 12, 1896		6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.	
10. CITY OR TOWN OF DEATH Baltimore City		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Union Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker 12b. KIND OF BUSINESS OR INDUSTRY	

13a. STATE Md.		13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 102 W. 39th St. Apt 4A 21210
14. FATHER'S NAME FIRST MIDDLE LAST Vernon L. Hall			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Ida Benson		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216 03 8054		17. INFORMANT ADDRESS Mr. Robert R. Johnson 102 W. 39th St. 21210	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 minutes</u> <u>10 min</u>	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <u>renal insufficiency @ colon cancer</u>			
19a. DATE OF OPERATION 11/24/86	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED colon cancer	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>11/20</u> , 19 <u>86</u> , to <u>12/22</u> , 19 <u>86</u> , that (we) last saw the deceased alive on <u>11/22</u> , 19 <u>86</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>Roy D. Chisholm</u>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED 11/22/86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Roy D. Chisholm, M.D.		22e. ADDRESS The Union Memorial Hospital	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 12/24/86	23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.
24. FUNERAL DIRECTOR MAYN MITCHELL-WIEDEFELD HOME, INC.		25a. DATE REC'D. BY REGISTRAR DEC 30 1986	25b. REGISTRAR'S SIGNATURE Julia L. Baker-Rodney

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return all papers. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified of case.

MEDICAL CERTIFICATION

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26496 DEC-9 1986

FOR Items 8 3-2-89 Film649
STATE REGISTRAR W.H.STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Arthur D. JOHNSON			2a. DATE OF DEATH MONTH DAY YEAR 12-03-86		2b. HOUR 5:10 P.M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 8 02 26		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
10. CITY OR TOWN OF DEATH Baltimore			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Frances Scott Key Med. Cent.			
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machinist, Crown, Cork & Seal			12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore	
14. FATHER'S NAME FIRST MIDDLE LAST Watson D. Johnson			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Susie V. Reid			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W.2		17. INFORMANT ADDRESS Balto. Md. 21224 Brenda Hopkins, 319 S. Highland Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 9289 IMMEDIATE CAUSE (a) CARDIAC Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Severe Neurological Injury : Chronic Atrial Fibrillation						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from Dec 3 , 19 86 , to Dec 5 , 19 86 , that (I) (we) last saw the deceased alive on Dec 3 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.						
22b. SIGNATURE Laura Marsh				22c. DATE SIGNED 12/3/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LAURA MARSH				22e. ADDRESS ESMC 4940 EASTERN AVE. BALTO, MD		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/6/86		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Pk.		
23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie, A.A. Co Md						
24. FUNERAL DIRECTOR NAME Balto. Md. 21230 McCully Funeral Home, 130 E. Fort Ave.				25a. DATE REC'D. BY REGISTRAR DEC 8 1986		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove complete pages 1, 2, 3, and 4 and file them in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or item 19 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84

(VRS 15, 4)

026334 DEC 18 1986

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3 4 5 6 0
REG. NO.

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST: ALLEN, MIDDLE: D., LAST: JOHNSON			2a. DATE KNOWN OF DEATH MONTH: 12, DAY: 3, YEAR: 1986		2b. HOUR M: 11:55, P: 55
3. SEX M	4. RACE B	5. DATE OF BIRTH MONTH: 9, DAY: 19, YEAR: 68	6. AGE (IN YEARS) 18 YRS.	7c. DATE PRONOUNCED DEAD MONTH: 12, DAY: 3, YEAR: 1986	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1918 Burnwood Rd.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) STUDENT	
12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE MD			13b. COUNTY	13c. CITY OR TOWN BALTO.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST: WILLIAM, MIDDLE: T., LAST: JOHNSON, JR.			15. MOTHER'S MAIDEN NAME FIRST: LEGERALD, MIDDLE: TURRENTINE, LAST: TURRENTINE		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 220023893		17. INFORMANT ADDRESS: LEGERALD JOHNSON 1912 SWANSEA RD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot wound of neck (unspecified weapon)</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR: 11:45, MONTH: 12, DAY: 3, YEAR: 1986		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject shot.	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) house		21f. LOCATION STREET: 1918 Burnwood Rd., CITY OR TOWN: Balto., COUNTY: MD	
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Charles P. Kokes</i>		TITLE (SPECIFY) M.D. Assistant		DATE SIGNED 12-4-86	
EXAMINER'S NAME (TYPE OR PRINT) Charles P. Kokes, M.D.		ADDRESS 111 Penn St., Balto., MD 21201			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12-8-86		23c. NAME OF CEMETERY OR CREMATORY GARRISON FOREST CEM	
24. FUNERAL DIRECTOR NAME MARCHE FUNERAL HOME		ADDRESS 1101 E. NORTH AVE.		25a. DATE REC'D. BY REGISTRAR DEC 5 1986	
25b. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>		25c. LOCATION CITY OR TOWN: OWINGS MILLS, COUNTY: MD			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

12 COTTON FIBER

MADE IN U.S.A.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death of a patient be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) EDNA		FIRST L. MIDDLE (LORRAINE) LAST JOHNSON		2a. DATE OF DEATH MONTH DAY YEAR 12/13/86		2b. HOUR 1530 M	
3. SEX FEMALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 2 13 06		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. 80	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA, U.S.A.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTO.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) UNEMP.		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. STREET ADDRESS / ZIP CODE 1510 Mosher St. Apt. 30 21217	
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM JOHNSON		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SARAH LEWIS		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 218222226	
17. INFORMANT ADDRESS DELORES GLADDEN 1240 N. CURLEY ST.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) PRESUMED RUPTURED INTRACRANIAL DUE TO, OR AS A CONSEQUENCE OF (c) ANEURYSM APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 45 MIN.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION NONE		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12/13 , 19 86 , to 12/13 , 19 86 , that (I) (we) last saw the deceased alive on 12/13 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) did (did not) view the body after death.							
22b. SIGNATURE Michael G. Macoz		DEGREE M.D.		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/13/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL G. MACON, M.D.		22e. ADDRESS 900 CATON AVE. BALTIMORE MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12-19-86		23c. NAME OF CEMETERY OR CREMATORY MD. NATIONAL MEM. PK.		23d. LOCATION CITY OR TOWN COUNTY STATE LAUREL MD	
24. FUNERAL DIRECTOR NAME MARCH FUNERAL HOME		ADDRESS 1101 E. NORTH AVE.		25a. DATE REC'D. BY REGISTRAR DEC 18 1986		25b. REGISTRAR'S SIGNATURE Julia Siskin-Rudesh	

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STATE OF NEW YORK

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RECORDS

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December 22, 1950

Mr. J. Edgar Hoover

Washington, D.C.

Dear Mr. Hoover:

I am writing you to inform you that

the following information

was received from the Bureau of the

Internal Security - Communist Party, U.S.A.

on December 21, 1950.

The information was received from

the Bureau of the Internal Security -

Communist Party, U.S.A.

on December 21, 1950.

The information was received from

the Bureau of the Internal Security -

Communist Party, U.S.A.

on December 21, 1950.

The information was received from

026200 DEC 5 1986

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 3 4 5 6 3

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) GERTRUDE C JOHNSON			2a. DATE OF DEATH MONTH DAY YEAR 12 / 1 / 86		2b. HOUR 5:28 PM
3. SEX FEMALE	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR 9 / 17 / 23		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES Hosp.		12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND			13b. COUNTY	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Wilson Cole			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY FREDERICK		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS CHART	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) ASPIRATION PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF (b) CEPHALOVASCULAR ACCIDENT Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) HYPERTENSION					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) RENAL FAILURE, GI BLEEDING					
19a. DATE OF OPERATION NO		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 11 / 21 , 19 86 , to 12 / 1 , 19 86 , that (I) (we) lost saw the deceased alive on 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Dean S. Tippet MD		DEGREE MD		22c. DATE SIGNED 12/1/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DEAN S. TIPPETT		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/6/86		23c. NAME OF CEMETERY OR CREMATORY GARRISON FOREST VET.	
23d. LOCATION CITY OR TOWN COUNTY STATE OWINGS MILLS MARYLAND		24. FUNERAL DIRECTOR NAME ADDRESS E. L. Phillips 1721-27 N. MONROE ST.			
25a. DATE REC'D. BY REGISTRAR DEC 4 1986		25b. REGISTRAR'S SIGNATURE Julia Davidson-Pendash			

MEDICAL CERTIFICATION

29

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the medical certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the other papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

BP

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6

3 4 5 6 4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Hattie C. Johnson			2a. DATE OF DEATH MONTH DAY YEAR 12-12-86			2b. HOUR 4:00 A.M.				
3 SEX Female		4 RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 5 3 1913		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 73		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore city MD.				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2702 Rosedale St. 21216				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2702 Rosedale St. 21216	
14. FATHER'S NAME FIRST MIDDLE LAST Robert Williams			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Roberta Coates							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-22-8853		17. INFORMANT ADDRESS Calvin Johnson					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic endometrial cancer DUE TO, OR AS A CONSEQUENCE OF (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from July 30, 1985 , to Dec , 19 86 , that (I) (we) last saw the deceased alive on November 13, 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Jeffrey Abrams MD					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 12/15/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jeffrey Abrams					22e. ADDRESS U.Md. Cancer 22 S. Greene St Balt., Md 21201					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12-16-86		23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland			
24. FUNERAL DIRECTOR NAME Bailey Funeral Home 1348 N. Calhoun St. 21217					25a. DATE REC'D. BY REGISTRAR DEC 16 1986		25b. REGISTRAR'S SIGNATURE Julia Gordon-Randall			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____



26488 DEC -9

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) HATTIE V. JOHNSON			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 4, 1986		2b. HOUR MIN. 8:45AM
3 SEX FEMALE	4 RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR 3 21 1911		6 AGE (IN YEARS LAST BIRTHDAY) 75 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 72 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CHURCH HOME HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DIETARY AIDE.		12b. KIND OF BUSINESS OR INDUSTRY PROVIDENT HOSP.
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND			13b. COUNTY BALTIMORE		
13c. CITY OR TOWN BALTIMORE			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST MOSES EWELL			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HATTIE RICHARDSON		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO.		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 174-18-6123		17. INFORMANT MRS. HILDA B. SAUNDERS ADDRESS Baltimore, Md. 21202 501 E. Preston St. Apt. 41	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UROSEPSIS DUE TO, OR AS A CONSEQUENCE OF (b) CEREBROVASCULAR ACCIDENT DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) this hospital attended the deceased from NOVEMBER 9, 1986 to DECEMBER 4, 1986 , that (I) (we) last saw the deceased alive on DECEMBER 4, 1986 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (we) (did) not view the body after death.					
22b. SIGNATURE <i>A. R. Nazemi M.D.</i>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/4/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ATAOLLAH NAZEMI M. D.		22e. ADDRESS CHURCH HOSPITAL CORPORATION 100 NORTH BROADWAY BALTIMORE, MD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/09/1986		23c. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Park	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland		23e. ZIP CODE 21231			
24. FUNERAL DIRECTOR NOTER & SONS FUNERAL HOME, INC. 2501 Gwynns Falls Pkwy. Baltimore, Md. 21216		25a. DATE REC'D. BY REGISTRAR DEC 8 1986		25b. REGISTRAR'S SIGNATURE <i>Julia Benson-Randall</i>	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

WITTENBERG, J. & J. WITTENBERG, INC.

128226 DEC 29 1986

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Herbert H. Johnson			2a. DATE OF DEATH MONTH DAY YEAR 12 23 86		2b. HOUR 4:30 [#] M
3. SEX M	4. RACE B	5. DATE OF BIRTH MONTH DAY YEAR 07 04 45		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 71 66 IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA	7b. CITIZEN OF WHAT COUNTRY? US	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BON SECOURS HOSP		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) GRACKER	
12b. KIND OF BUSINESS OR INDUSTRY					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE MD	13b. COUNTY	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 329 GWYNN AVE 21229	
14. FATHER'S NAME FIRST MIDDLE LAST FRANK Johnson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EVA BANKS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 130-07-4033		17. INFORMANT ADDRESS Rebecca A. Johnson 329 GWYN AVE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO PULMONARY ANNIHILATION DUE TO, OR AS A CONSEQUENCE OF (b) LUNG CARCINOMA DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 11/7 , 19 86 , to 12/23 , 19 86 , that (I) <input checked="" type="checkbox"/> saw the deceased alive on 12/22 , 19 86 , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> did not view the body after death.					
22b. SIGNATURE John Shavers		DEGREE PHYSICIAN		22c. DATE SIGNED 12/23/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN SHAVERS		22e. ADDRESS 518 CAMP MEADOR RD. LINTHICUM, MD 21090			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/27/86		23c. NAME OF CEMETERY OR CREMATORY mt. Auburn Cem	
23d. LOCATION CITY OR TOWN COUNTY STATE Balto. MD.					
24. FUNERAL DIRECTOR NAME Locks Funeral Home		24b. ADDRESS 1304 N. Central Ave		25a. DATE REC'D. BY REGISTRAR DEC 24 1986	
25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall					

MEDICAL CERTIFICATION

99

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other significant condition, the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item 16b, Film G 622 12/30/86 rja

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | |
|---|--|---|---|---|--|---|------------------------------|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
Hobart W Johnson | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12/20/86 | | | 2b. HOUR
23:16 M | | |
| 3. SEX
M | | 4. RACE
W | | 5. DATE OF BIRTH
MONTH DAY YEAR
4 2 1916 | | 6. AGE (IN YEARS LAST BIRTHDAY)
70 YRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
KANSAS | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore MD. | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
St. Agnes Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired Federal Gov't | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Catonsville | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
203 Park Drive 21228 |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Carl O Johnson | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Esther | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO.
515-01-8577
218 44 1764 | | 17. INFORMANT
ADDRESS
Ellicott City
David Johnson 2812 Greenbower Way 21043 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hodgkins disease, Stage IV
DUE TO, OR AS A CONSEQUENCE OF
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
Renal failure, Disseminated intravascular coagulation | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (if this hospital) attended the deceased from December 10, 1986, to December 22, 1986, that (we) last saw the deceased alive on December 20, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE
Barbara Socha, M.D. | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED
12/20/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
BARBARA SOCHA | | | | 22e. ADDRESS
900 Caton Ave, Baltimore | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | 23b. DATE
Dec 22, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY
Westview Memorial Pk | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Catonsville Balto., Maryland | | |
| 24. FUNERAL DIRECTOR
NAME
Harry H Witzke & Family Funeral Home
Inc 4112 Old Columbia Pike Ellicott City | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 22 1986 | | 25b. REGISTRAR'S SIGNATURE
Julia Gordon-Brown | | |

BP

22



Carl Johnson

at night

at night

at night

1917-1918

Loc 411 Old Columbia Pike, Willsboro City
Harry E. Willsboro & Family Special
Dec 28 1917
Dec 28 1917
Willsboro, New York

027705

DEC 16 1986
FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
JOSEPH JOHNSON (SR) | | | 2a. DATE OF DEATH
MONTH DAY YEAR
DECEMBER 16, 1986 | | 2b. HOUR
DAY MIN.
1:20 A.M. | | |
| 3. SEX
M | | 4. RACE
B | | 5. DATE OF BIRTH
MONTH DAY YEAR
6 16 17 | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS. MONTHS DAYS HOURS MIN.
69 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
S C | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
JOHNS HOPKINS HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
RETIRED | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
S C | | 13b. COUNTY
MARLBORO | | 13c. CITY OR TOWN
MARLBORO | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
MARION A JOHNSON | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
UNK | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
UNK | |
| 17. INFORMANT
SALLIE MACKLIN | | ADDRESS
5125 DARIEN RD 21206 | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary Arrest
DUE TO, OR AS A CONSEQUENCE OF (b) Arrest
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (c) metastatic cancer | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
0 minute
1 minute
2 months | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
pneumonia | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/7 , 19 86 , to 12/16 , 19 86 , that (I) (we) lost saw the deceased alive on 12/16 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
AJL | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
12/16 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
AMY KLION | | | | 22e. ADDRESS
600 N. Wolfe St. BALTO. Md 21205 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
12-18 86 | | 23c. NAME OF CEMETERY OR CREMATORY
NELSON FUNERAL HOME ROCKINGHAM | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
ROCKINGHAM N.C. | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
MARCHE FUNERAL HOME 1101 E. NORTH AVE | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 17 1986 | | 25b. REGISTRAR'S SIGNATURE
Lia Benson-Rodner | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please send it, containing pages 1 and 2, should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|--|---|---|---|--|
| 1. DECEASED NAME
FIRST MIDDLE LAST
Lizzie (MAE.) Johnson | | | 2a. DATE OF DEATH
MONTH DAY YEAR
December 19, 1986 | | 2b. HOUR
12:45 PM |
| 3. SEX
Female | 4. RACE
Black | 5. DATE OF BIRTH
MONTH DAY YEAR
3 2 02 | 6. AGE (IN YEARS LAST BIRTHDAY)
84 YRS. | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
FLORIDA | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY, MD. | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
VALLEY NURSING & CONVALSCENT CTR. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
BARMAID | 12b. KIND OF BUSINESS OR INDUSTRY
RETIRED | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MD | | | 13b. COUNTY
BALTO. | 13c. CITY OR TOWN
BALTO. | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
UNK | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE
MARY YOFF | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
267224720 | | 17. INFORMANT
ADDRESS
GRACE WHITE 1603 GORSUCH AVE, 21218 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Arteriosclerotic Coronary Artery Disease</u>
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | |
| MEDICAL CERTIFICATION | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED
(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>12-26-86</u> to <u>12-19-86</u> , that (I) (we) lost saw the deceased alive on <u>12-15-86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>M. C. Kowalewski</u> | | DEGREE
MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12-19-86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
M. C. KOWALEWSKI | | 22e. ADDRESS
8604 H ARFORD RD 21234 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | 23b. DATE
12 23 86 | 23c. NAME OF CEMETERY OR CREMATORY
MT. AUBURN CEMETERY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTO MD | |
| 24. FUNERAL DIRECTOR
NAME
March Funeral Homes | | ADDRESS
1101 East North Avenue | | 25a. DATE REC'D. BY REGISTRAR
DEC 21 1986 | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial transit permit. Then please remove colored papers. Pages 1 and 2 should be filed with the Registrar after deal with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

027203 DEC 16 1986

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 10. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

1- DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

MARGUERITE E. JOHNSON

2a. DATE KNOWN
OF
DEATH ESTI-
MATED ☒ MONTH DAY YEAR

2b. HOUR
12-12-86

3. SEX

Female

4. RACE

White

5. DATE OF BIRTH
MONTH DAY YEAR
12 3 32

6. AGE (IN YEARS)
LAST BIRTHDAY
54 YRS.

IF UNDER 1 YR.
MONTHS DAYS HOURS MIN.

IF UNDER 24 HRS.
MONTHS DAYS HOURS MIN.

7c. DATE
PRONOUNCED
DEAD
12-12-86

7d. HOUR
7:09a

7a. BIRTHPLACE (STATE OR
FOREIGN COUNTRY)
Maryland

7b. CITIZEN OF WHAT COUNTRY?
U.S.A.

8. MARRIED ☒ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City

10. CITY OR TOWN OF DEATH
Baltimore

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
3031 Mallview Road

12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE)
Assembly Line

12b. KIND OF BUSINESS
OR INDUSTRY
Umbrella

13a. STATE
Maryland

13b. COUNTY
Baltimore

13c. CITY OR TOWN
Baltimore

13d. INSIDE CITY LIMITS?
YES ☒ NO ☐

13e. STREET ADDRESS
3031 Mallview Road 21230

14. FATHER'S NAME
FIRST MIDDLE LAST
George A. Fisher

15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Alice Schnieder

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No

16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
218-28-6136

17. INFORMANT
ADDRESS
James J. Johnson Same as 13e

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a) stating the under-
lying cause last.

(b) _____
DUE TO, OR AS A CONSEQUENCE OF

(c) _____

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS

UNDERLYING ☐ OR
CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED
WHILE ☐ NOT WHILE ☐
AT WORK AT WORK

21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.)

21f. LOCATION
STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐.

ACTUAL
SIGNATURE

Margarita A. Korell

TITLE (SPECIFY)

Assistant

MEDICAL EXAMINER

DATE 12-12-86
SIGNED

EXAMINER'S NAME
(TYPE OR PRINT)

Margarita A. Korell, M.D.

ADDRESS

111 Penn Street

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation

23b. DATE
12/15/86

23c. NAME OF CEMETERY OR CREMATORY
Westview Mem Park

23d. LOCATION
CITY OR TOWN
Catonsville

COUNTY Balto STATE Md

24. FUNERAL DIRECTOR

George J. Gonce 4001 Ritchie Hgwy Balto Md

25a. DATE REC'D. BY REGISTRAR

DEC 15 1986

25b. REGISTRAR'S SIGNATURE

Julia Davidson-Randall

07/84
25M

BP
DHMH - 17
(VR A15 ME (5))

026583 DEC 10 1986

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0 3 4 5 7 1

REG. NO.

| | | | | | |
|--|---|---|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Nellie M. Johnson | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 4 86 | | 2b. HOUR
M
AM |
| 3. SEX
Fem. | 4. RACE
Cau. | 5. DATE OF BIRTH
MONTH DAY YEAR
2 26 08 | | 6. AGE (IN YEARS LAST BIRTHDAY)
78 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Balto. | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
2829 Brendan Ave. 21213 | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE 13b. COUNTY 13c. CITY OR TOWN
Md. Carroll Hampstead | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Joseph H. Johnson | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Dora A. Mitchell | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
no | | 16b. SOCIAL SECURITY NO.
219-18-9426 | | 17. INFORMANT ADDRESS
Eunice E. Johnson 2829 Brendan Ave. 21213 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Arrest.
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
10 yrs |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)
Chronic obstructive pulmonary disease | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
11 11 1986 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
3223 Main St Box E
Manchester, Md 21112 | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/24 , 19 86 , to 12/4 , 19 86 , that (we) lost saw the deceased alive on 11/18 , 19 86 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
W. H. Howard MD | | DEGREE | | 22c. DATE SIGNED
12/6/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
W. H. Howard MD | | 22e. ADDRESS
3223 Main St Box E
Manchester, Md 21112 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
12-8-86 | | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park Cem. | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto. Md. | | 24. FUNERAL DIRECTOR
NAME ADDRESS
John C. Miller Inc. 6415 Belair Rd. 21206 | | 25a. DATE REC'D. BY REGISTRAR
DEC 9 1986 | |
| | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked as item 18, then any injury, or other traumatic event, or other cause of death, must be certified by a physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 0 3 4 5 1 2 | |
|---|--|---|--|--|--|
| 1- FOR STATE REGISTRAR | | | | CERTIFICATE OF DEATH | |
| 2a. DATE OF DEATH | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
<i>Onzea S. William (JOHNSON)</i> | | | | 2b. DATE OF DEATH MONTH DAY YEAR HOUR
<i>12 13 86</i> M | |
| 3. SEX
<i>Male</i> | | 4. RACE
<i>black</i> | | 5. DATE OF BIRTH MONTH DAY YEAR
<i>11 21 86</i> | |
| 6. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>MD</i> | | 7. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Baltimore City</i> MD | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| 10. CITY OR TOWN OF DEATH
<i>Balto</i> | | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>St. Agnes Hosp</i> | | | | 13a. STATE <i>MD</i> 13b. COUNTY <i>BALTIMORE</i> 13c. CITY OR TOWN <i>Baltimore</i> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
<i>Curtis Williams</i> | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
<i>Kim Johnson</i> | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
<i>N/A</i> | | | | 16b. SOCIAL SECURITY NO.
<i>N/A</i> | |
| 17. INFORMANT ADDRESS
<i>Kim Johnson 3109 Elba Dr.</i> | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Cardio Respiratory Arrest</i>
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Brain Death</i>
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Hypoxia</i> | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
<i>Prematurity</i> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
<i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>11/21</i> , 19 <i>86</i> , to <i>12/13</i> , 19 <i>86</i> , that (I) (we) last saw the deceased alive on <i>12/13</i> , 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE DEGREE
<i>[Signature]</i> | | | | 22c. DATE SIGNED
<i>12/13/86</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>Andrea Orphanos M.D.</i> | | | | 22e. ADDRESS
<i>SAH 900 Caton Ave Baltimore, Md.</i> | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
<i>Burial</i> | | 23b. DATE
<i>12/18/86</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Cedar Hill Cem.</i> | |
| 24. FUNERAL DIRECTOR NAME
<i>Wm C March F/H West</i> | | ADDRESS
<i>4300 Wabash Ave.</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE
<i>Anne Arundel Co., Md.</i> | |
| 25a. DATE REC'D. BY REGISTRAR
<i>DEC 16 1986</i> | | | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | |

1. The first part of the report is a general description of the work done during the year. It includes a list of the projects undertaken and a summary of the results achieved. The second part of the report is a detailed account of the work done on each project. It includes a description of the methods used, the results obtained, and a discussion of the significance of the work. The third part of the report is a summary of the work done during the year. It includes a list of the projects undertaken and a summary of the results achieved. The fourth part of the report is a detailed account of the work done on each project. It includes a description of the methods used, the results obtained, and a discussion of the significance of the work. The fifth part of the report is a summary of the work done during the year. It includes a list of the projects undertaken and a summary of the results achieved. The sixth part of the report is a detailed account of the work done on each project. It includes a description of the methods used, the results obtained, and a discussion of the significance of the work. The seventh part of the report is a summary of the work done during the year. It includes a list of the projects undertaken and a summary of the results achieved. The eighth part of the report is a detailed account of the work done on each project. It includes a description of the methods used, the results obtained, and a discussion of the significance of the work. The ninth part of the report is a summary of the work done during the year. It includes a list of the projects undertaken and a summary of the results achieved. The tenth part of the report is a detailed account of the work done on each project. It includes a description of the methods used, the results obtained, and a discussion of the significance of the work.

028644 DEC 31

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | |
|---|--|---|---|---|----------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Grace JOHNSON | | | 2a. DATE OF DEATH
MONTH DAY YEAR
December 24, 1986 | | 2b. HOUR
1:00P M | |
| 3. SEX
Female | | 4. RACE
Negro | | 5. DATE OF BIRTH
MONTH DAY YEAR
4 15 16 | | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
70 YRS. | | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Va. | | 8. CITIZEN OF WHAT COUNTRY?
U.S.A. | | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | | 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Maryland General Hospital | | |
| 12a. USUAL OCCUPATION
(GIVE IF WORK FOR MOST OF WORKING LIFE)
Domestic | | 12b. KIND OF BUSINESS OR INDUSTRY
Private Homes | | 13. STREET ADDRESS - ZIP CODE
2506 Madison Ave 21217 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Wirey Stevenson | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Sadie Hall | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | |
| 16b. SOCIAL SECURITY NO. | | 17. INFORMANT
ADDRESS
Sadie Hall 715 Short St. Pocomoke, Md. | | | | |

| | | | |
|---|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line - (a), (b), and (c)) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a)
Carcinoma of the rectum, with extensive metastases. | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Chronic irreversible emphysema | | | |
| (c) DUE TO, OR AS A CONSEQUENCE OF | | | |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from November 8 , 19 86 , to December 24 , 19 86 , tho <input checked="" type="checkbox"/> (we) last saw the deceased alive on December 24 , 19 86 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (we) did not view the body after death. | | | | | | | |
| 22b. SIGNATURE
Mien-Door Kioune | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12-24-86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Mien-Door Kioune, M.D. | | | | 22e. ADDRESS
c/o Maryland General Hospital | | | |

| | | | | | | | |
|--|--|------------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
12-30-86 | | 23c. NAME OF CEMETERY OR CREMATORY
Union Bap. Cme | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Chincoteague Accomack Va. | |
| 24. FUNERAL DIRECTOR
NAME
Savage's Funeral | | | | 25. DATE REC'D. BY REGISTRAR REGISTRAR'S SIGNATURE
DEC 29 1986 | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please send page 4 to the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0 3 4 3 7 4

1 - FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|---|---|---|---|--|
| DECEASED NAME
(TYPE OR PRINT)
MILTON JOHNSON | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 21 86 | | 2b. HOUR
M | |
| 3. SEX
male | 4. RACE
Black | 5. DATE OF BIRTH
MONTH DAY YEAR
01 07 13 | | 6. AGE (IN YEARS (LAST BIRTHDAY))
73 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
BALTO., MD. | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Liberty Medical Center | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
FIREMAN | | 12b. KIND OF BUSINESS OR INDUSTRY
COAL FND. |
| 13a. STATE
MARYLAND | | 13b. COUNTY
BALTIMORE | 13c. CITY OR TOWN
BALTIMORE | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
MILTON JOHNSON | | 15. MOTHER'S MAIDEN NAME
MARY SMITH | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
218-10-4667 | | 17. INFORMANT
MARGARET JOHNSON | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiopalm arrest</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>lung mass</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>dehydration</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/19/86 to 12/21/86, that (I) (we) last saw the deceased alive on 12/21/86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
T. Ohiokepehai, MD | | | | 22c. DATE SIGNED
12/21/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
T. Ohiokepehai, MD | | | | 22e. ADDRESS
Liberty Medical Center | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
12-26-86 | | 23c. NAME OF CEMETERY OR CREMATORY
CEDAR HILL | |
| 23d. LOCATION
(CITY OR TOWN) COUNTY STATE
BALTIMORE MARYLAND | | 23e. DATE REC'D. BY REGISTRAR
DEC 30 1986 | | | |
| 24. FUNERAL DIRECTOR
NAME
BROWN/Thompson F.H. | | ADDRESS
1913 W BALTO. ST | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be attached for use as the burial transit permit. Then please remove carbon papers. Page 4 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner and the medical examiner's report should be attached to this certificate.

BP



DEC 30 1988

026378 DEC-31-1986

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 3 4 5 1 5

| | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|---|--|---|--|--|--|------------------|--|
| 1. DECEASED NAME
(Type or Print) | | FIRST MIDDLE LAST | | 2a. DATE OF DEATH | | | | MONTH DAY YEAR | | 2b. HOUR | | | | | |
| RICHARD | | JOHNSON | | 12 | | | | 4 | | 86 | | 4:35A | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | |
| M | | B | | 9/7/26 | | | | 60 YRS. | | | | MONTHS | | DAYS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | |
| Balto., Md. | | U.S.A. | | | | | | Balto., City MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Balt. | | Francis Scott Key Medical Ctr | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13b. STATE | | 13c. COUNTY | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS / ZIP CODE | | | | | |
| MD. | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 1527 Northwick Ave. 21218 | | | | | |
| 14. FATHER'S NAME (Type or Print) | | | | 15. MOTHER'S MAIDEN NAME (Type or Print) | | | | | | | | | | | |
| Richardson Johnson | | | | Isabelle Lee | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | | 17. INFORMANT | | | | ADDRESS | | | | | |
| yes | | | | WWII | | Elaine Johnson | | | | 1527 Northwick Ave. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Cardiac Arrest | | | | | | | | | | | | 30 mins. | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
| (b) Sepsis | | | | | | | | | | | | 4 weeks | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
| (c) Infected Renal Transplant wound | | | | | | | | | | | | 4 weeks | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | | | | | | | |
| Chronic Renal Failure | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 11/13/86 | | | | Renal Transplant Nephrectomy | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| | | | | P.M. 19 | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION STREET | | CITY OR TOWN | | COUNTY STATE | | | |
| | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/28, 1986, to 12/4, 1986, that (I) (we) last saw the deceased alive on 12/4, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | DEGREE | | 22c. DATE SIGNED | | | | | |
| Steven C. Marks | | | | | | | | MD | | 12/4/86 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | | | 22e. ADDRESS | | | | | | | |
| Steven C. Marks | | | | | | | | Francis Scott Key Medical Center - Balto., MD | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | |
| Burial | | | | 12/8/86 | | garrison Forest | | | | Owings Mills, Md. | | | | | |
| 24. FUNERAL DIRECTOR NAME | | | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| Leroy O. Dyett 4600 Liberty Heights Ave. | | | | | | | | DEC 5 1986 | | Julia Gordon | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon copies, page 3 with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the hospital or attending physician.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

100-150000

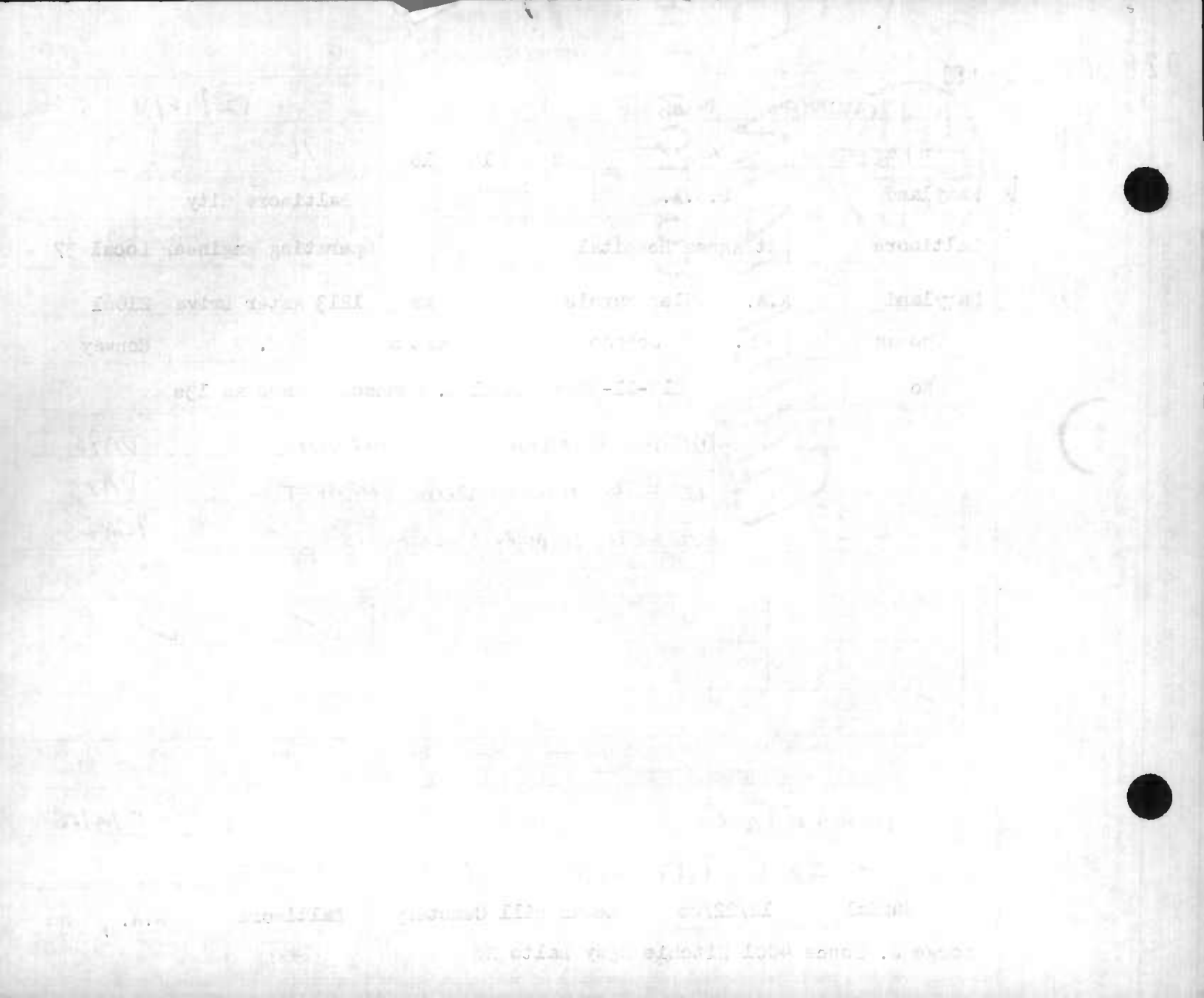


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 8 6 3 4 5 7 0
REG. NO. | | | | | | | |
|--|--|--|--|--|--|---|--|--|--|---|--|---|--|--|--|------------------|--|
| 1. FOR STATE REGISTRAR | | DECEASED NAME (TYPE OR PRINT) | | | | FIRST MIDDLE LAST | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | | 2b. HOUR | | | |
| | | THOMAS MONROE JOHNSON | | | | | | | | 12/18/86 | | | | 5 ³⁵ P.M. | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR | | 8. IF UNDER 24 HRS | | | | | | | |
| MALE | | WHITE | | 2 13 10 | | 76 | | MONTHS | | DAYS | | HOURS | | MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | |
| Maryland | | U.S.A. | | | | Baltimore City MD. | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Baltimore | | St Agnes Hospital | | | | | | | | | | Operating Engineer | | Local 37 | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. STATE | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | | | | | |
| Maryland | | A.A. | | Glen Burnie | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 1213 Aster Drive 21061 | | | | | | | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | |
| FIRST MIDDLE LAST | | | | FIRST MIDDLE LAST | | | | | | | | | | | | | |
| Thomas M. Johnson | | | | Martha E. Conway | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | | | | | | | |
| No | | | | 213-01-5085 | | Ethel A. Johnson Same as 13e | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| IMMEDIATE CAUSE (a) MASSIVE BILATERAL PNEUMONIA | | | | | | | | | | | | | | DAYS | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | | | DAYS | | | |
| b) ACUTE MYOCARDIAL INFARCTION | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | |
| c) MARKED ATHEROSCLEROSIS | | | | | | | | | | | | | | YEARS. | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | | |
| | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| | | | | P.M. 19 | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION | | | | | | | | | |
| WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | | | | | STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost | | | | | | | | | | | | | | | | | |
| saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated | | | | | | | | | | | | | | | | | |
| above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | | | | | | DEGREE | | 22c. DATE SIGNED | |
| James E. Taylor | | | | | | | | | | | | | | M.D. | | 12/19/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | | | | | | | | | 22e. ADDRESS | | | |
| JAMES E. TAYLOR, M.D. | | | | | | | | | | | | | | St Agnes Hospital. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION | | COUNTY | | STATE | | | |
| Burial | | | | 12/22/86 | | Cedar Hill Cemetery | | | | Baltimore | | A.A. | | Md | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | 25a. DATE REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| George J. Gonce 4001 Ritchie Hwy Balto Md | | | | | | | | | | DEC 22 1986 | | Julia Gordon-Ritter | | | | | |

BP



027169 DEC 1986

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove certain parts of the certificate and return them to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition. Page 4 should be filed within 72 hours after death. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause of death, the medical examiner must be notified at once.

DHMH - 16 60M 7/B4
(VRA 15, 4)

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 86 34511 | |
|---|--|---|--|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
WILLIAM H JOHNSON | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
12/11/86 | | | 2b. HOUR
6:30 A.M. | | |
| 3. SEX
male | | 4. RACE
Black | | 5. DATE OF BIRTH MONTH DAY YEAR
7 1 16 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS HOURS MIN.
70 | | | IF UNDER 1 YEAR
IF UNDER 24 HRS | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Baltimore, Md | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN THIS FACILITY, GIVE STREET ADDRESS)
Bronson Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Laborer | | | 12b. KIND OF BUSINESS OR INDUSTRY
none | | |
| 13a. USUAL RESIDENCE (IF MAKING HOME OR OTHER INSTITUTION GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
2604 W Bayview #2123 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
William H. Johnson Sr. | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Annice Brown | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
yes | | 16b. SOCIAL SECURITY NO.
220-0903604 | | 17. INFORMANT NAME
Matthew Johnson | | | | ADDRESS
3604 Johnson #2123 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) METASTATIC ADENOCARCINOMA
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/15 , 19 86 , to 12/11 , 19 86 , that (I) <input checked="" type="checkbox"/> saw the deceased alive on 12/10 , 19 86 , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above; (I) <input type="checkbox"/> did not view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
John Shaver | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
12/11/86 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JOHN SHAVER | | | | 22e. ADDRESS
518 CAMP MARIETTA LINTHICUM, MD | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
Burial | | | | 23b. DATE
12/16/86 | | 23c. NAME OF CEMETERY OR CREMATORY
Greenwood | | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Baltimore Md | | |
| 24. FUNERAL DIRECTOR
William H. Johnson | | | | ADDRESS
2322 W. North | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
DEC 12 1986 Julia Davidson-Randall | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

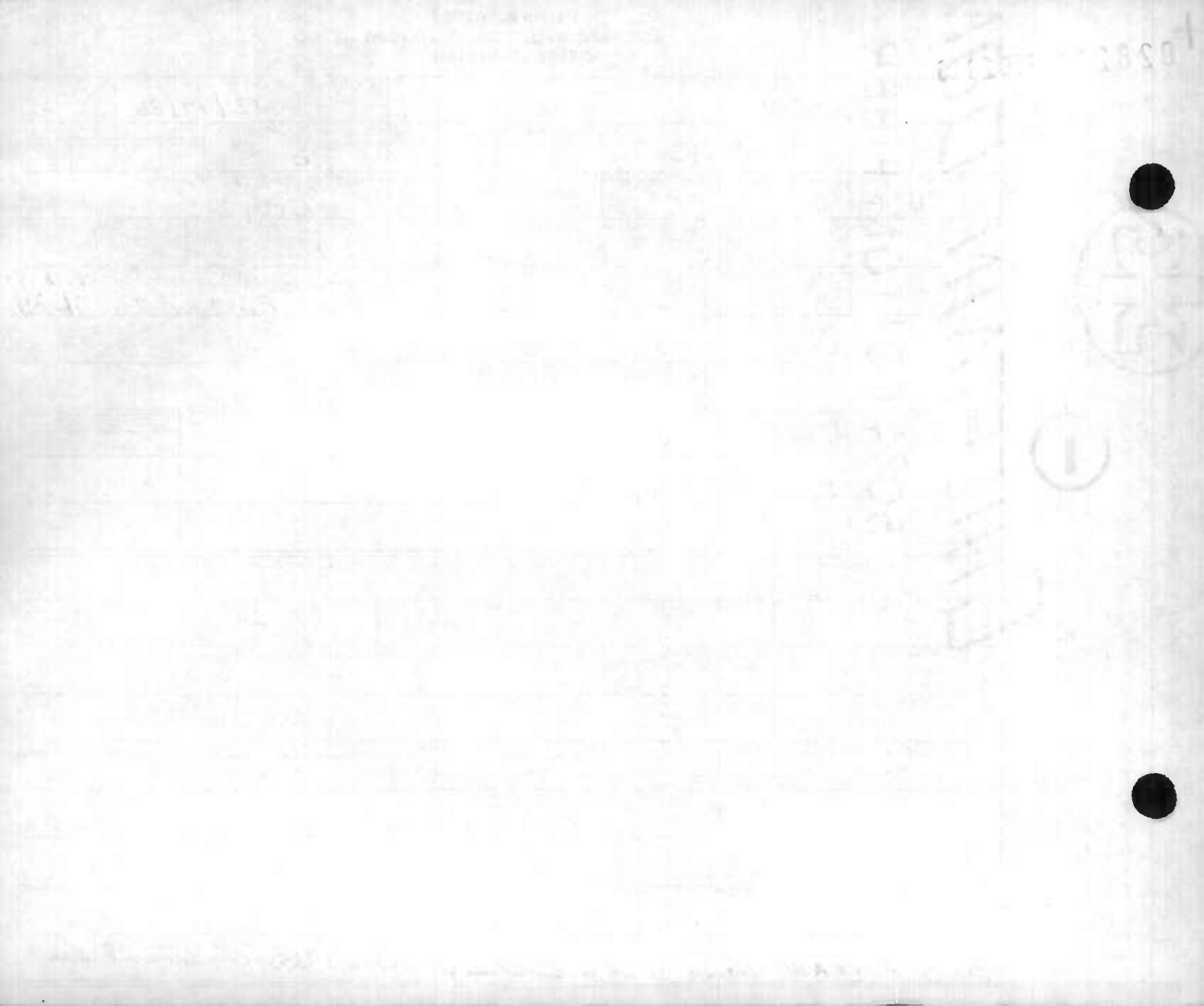
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified by name.

DHMH - 16 60M 7/B4
(VRA 15, 4)

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|--|--|--|--|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE DECEASED)
FIRST MIDDLE LAST
VINCENT JOHNSTON | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12/17/86 | | | | 2b. HOUR
HOURS MIN.
22⁵⁵ PM | |
| 3. SEX
M | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
8 15 10 | | 6. AGE (IN YEARS LAST BIRTHDAY)
76 YRS | | IF UNDER 1 YEAR
MONTHS DAYS
76 | | IF UNDER 24 HRS
HOURS MIN.
76 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
USA | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
BALTO. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
MASON F. LORD Nursing Home | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
unknown | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
M.D. | | | | 13b. COUNTY | | 13c. CITY OR TOWN
BALTO. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
MASON F. LORD N.H. 15200 Eastern Ave 21224 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
unknown | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
unknown | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO.
unknown | | 17. INFORMANT ADDRESS
Commission on Aging | | | | | |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory arrest
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pneumonia
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
hours | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no | | | | | | | | | | | |
| 19a. DATE OF OPERATION
12/17 | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/17 , 19 86 , to 12/17 , 19 86 that (I) (we) last saw the deceased alive on 12/17 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. | | | | | | | | | | | |
| 22b. SIGNATURE
Joseph G. Cuslander | | | | | | DEGREE
M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12/22/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JOSEPH G. CUSLANDER | | | | | | 22e. ADDRESS
5200 Eastern Ave Balt 21224 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(CHECK) | | | | 23b. DATE
12/23/86 | | 23c. NAME OF CEMETERY OR CREMATORY
MT. ZION CEM. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTO. 4 D. | | | |
| 24. FUNERAL DIRECTOR
NAME
BETH'S FUNERAL Home 1125 N. Caroline St | | | | | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR
DEC 23 1986 | | 25b. REGISTRAR'S SIGNATURE
Julia Sinden-Rudner | |

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN THE SPACE PROVIDED. PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER. PAGES 1, 2, AND 3 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 34579 | |
|--|--|----------------------|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Herman John Jolly | | | | | | 2a. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 12 6 1986 | | 2b. HOUR M | | | |
| 3. SEX male | | 4. RACE Black | | 5. DATE OF BIRTH
MONTH DAY YEAR Feb 3-1951 | | 6. AGE (IN YEARS)
LAST BIRTHDAY 35 YRS. | | 7c. DATE PRONOUNCED DEAD
MONTH DAY YEAR 12 6 1986 | | 7d. HOUR 9:37 P.M. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | |
| 11. CITY OR TOWN OF DEATH Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2531 E. Oliver Street | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Meat Cutter | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Md. | | | | | | 13b. COUNTY | | 13c. CITY OR TOWN Balto. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST Arthur Jolly | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST Beatrice Boyd | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO. 216-52-8622 | | 17. INFORMANT ADDRESS Arthur Jolly 2405 E. Federal St. 21213 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute alcoholic intoxication
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE Margie One Ynell | | | | TITLE (SPECIFY) M.D. Assistant | | | | DATE SIGNED 12/7/86 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. | | | | ADDRESS 111 Penn St. Balto, MD | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 12-11-86 | | 23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE Baltimore Md. | | | |
| 24. FUNERAL DIRECTOR
NAME Randolph J. Collick ADDRESS 2431 E. Oliver St. | | | | | | 25a. DATE REC'D. BY REGISTRAR DEC 16 1986 | | 25b. REGISTRAR'S SIGNATURE | | | |

027420 DEC

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

| | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|---|--|---|--|---------------------------------|--|---------------------|--|--------------------------------------|--|-------------|--|----------|--|------|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH | | MONTH | | DAY | | YEAR | | 2b. HOUR | | | | | |
| RICHARD | | | | JOLLY | | | | 12-13-86 | | | | | | | | M | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | MONTH | | DAY | | YEAR | | 2d. HOUR | |
| Male | | White | | 11 5 1927 | | 59 YRS. | | | | | | 12-13-86 | | | | | | | | 9:25 PM | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | NEVER MARRIED | | WIDOWED | | DIVORCED | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | MD | |
| Pennsylvania | | U. S. A | | X | | | | | | | | Baltimore City | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | |
| Baltimore | | Good Samaritan Hospital | | Inspector | | Lumber | | | | | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | | | | | | | | | |
| Pennsylvania | | Philadelphia | | Philadelphia | | YES X NO | | 1338 Harrison Street | | | | | | | | | | | | 19124 | |
| 14. FATHER'S NAME | | FIRST | | MIDDLE | | LAST | | 15. MOTHER'S MAIDEN NAME | | FIRST | | MIDDLE | | LAST | | | | | | | |
| Richard | | | | Jolly | | | | Mae | | | | | | Friese | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | | | | | | | | | |
| Yes | | WWII | | 169-22-1016 | | Vera Jolly | | 1338 Harrison St. Philadelphia, | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY: | | IMMEDIATE CAUSE (a) | | Arteriosclerotic cardiovascular disease | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | (b) | | DUE TO, OR AS A CONSEQUENCE OF | | (c) | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | | YES | | NO | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: | | Natural causes | | Accident | | Suicide | | Homicide | | Undetermined manner | | TITLE (SPECIFY) | | DATE SIGNED | | | | | | | |
| ACTUAL SIGNATURE | | M.D. | | Chief | | MEDICAL EXAMINER | | | | | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | John E. Smialek, M.D. | | ADDRESS | | 111 Penn Street | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | | | |
| Burial | | 12-19-86 | | Our Lady of Grace Cemetery | | Pewndel, Bucks, Pennsylvania | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | | |
| MARZULLO FUNERAL SERVICE | | UPPERCO, MD | | DEC 16 1986 | | Julia Gordon-Randall | | | | | | | | | | | | | | | |

FORM 17
(VR A15 ME (5))

0551-1-13-02

200-1101101-002

200-1101101-002

200-1101101-002

028125 DEC 20 1986

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) CHARLES (Charlie) JONES, SR | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 20 86 | | | 2b. HOUR
330 A | |
| 3. SEX
Male | | 4. RACE
B | | 5. DATE OF BIRTH
MONTH DAY YEAR
10 23 04 | | 6. AGE (IN YEARS LAST BIRTHDAY)
82 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
FLA. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore city MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Bon Secours Hospital | | 12a. USUAL OCCUPATION
(TYPE OR WORK IN MOST OF WORKING LIFE)
Retired | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
MD. | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Frank Jones | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
DeLynn Nancy Kemp | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO | | | |
| 16b. SOCIAL SECURITY NO.
082-05-9163 | | 17. INFORMANT
ADDRESS
Hattie L. Jones 3802 Cottage Ave | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) SEVERE CONGESTIVE HEART FAILURE
DUE TO, OR AS A CONSEQUENCE OF
(b) VALVULAR HEART DISEASE
DUE TO, OR AS A CONSEQUENCE OF
(c) CHRONIC JAUNDICE | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
MONTHS
Y4A23 |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
CHRONIC JAUNDICE | | | | | | | |
| 19a. DATE OF OPERATION
NONE | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/3 , 19 86 , to 12/20 , 19 86 , that (I) (we) last saw the deceased alive on DEC-20 , 19 86 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Charles Rosenfarb, MD | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12/21/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
CHARLES ROSENFARB, MD | | 22e. ADDRESS
700 WASHINGTON BLVD, BALTIMORE, MD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
12/23/86 | | 23c. NAME OF CEMETERY OR CREMATORY
Woodlawn Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore MD | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
March Funeral Home West 4300 Wabash Avenue | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 23 1986 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Rodgers | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this page to the State Dept. of Health and Mental Hygiene with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

16 FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|--|---|--|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Hattie F. Jones | | | 2a. DATE OF DEATH MONTH DAY YEAR 12-13-86 | | | 2b. HOUR 6:30 PM | | | |
| 3. SEX F | | 4. RACE B | | 5. DATE OF BIRTH MONTH DAY YEAR 04 18 25 | | 6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S.C. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALT CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Liberty MED Center | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Research Tech. | | 12b. KIND OF BUSINESS OR INDUSTRY Catalyst Research | |
| 13a. STATE MD | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Balto. | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 5062 CLIPTON AVE 21207 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Mack | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eliza Harrison | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 220-18-6234 | | 17. INFORMANT Bartina Elliott | | ADDRESS 5540 Karen Elaine Dr. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (b) | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: RESP FAILURE, RR | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/13 , 19 86 , to 12/13 , 19 86 , that (I) (we) last saw the deceased alive on 12/13 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE C. H. Jones DEGREE | | | | | 22c. DATE SIGNED 12/13/86 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) HARMATZ, ALEX | | | | | 22e. ADDRESS LIBERTY MED CENTER, BALT, MD | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 12/18/86 | | 23c. NAME OF CEMETERY OR CREMATORY King Mem. Pk. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Randallstown, Md. | | |
| 24. FUNERAL DIRECTOR NAME Wm C. March F/H West ADDRESS 4300 Wabash Ave. | | | | | 25a. DATE REC'D. BY REGISTRAR DEC 16 1986 | | 25b. REGISTRAR'S SIGNATURE Julia Gordon-Randall | | |

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1/10 1/11 1/12 1/13 1/14 1/15 1/16 1/17 1/18 1/19 1/20 1/21 1/22 1/23 1/24 1/25 1/26 1/27 1/28 1/29 1/30 1/31 1/32 1/33 1/34 1/35 1/36 1/37 1/38 1/39 1/40 1/41 1/42 1/43 1/44 1/45 1/46 1/47 1/48 1/49 1/50 1/51 1/52 1/53 1/54 1/55 1/56 1/57 1/58 1/59 1/60 1/61 1/62 1/63 1/64 1/65 1/66 1/67 1/68 1/69 1/70 1/71 1/72 1/73 1/74 1/75 1/76 1/77 1/78 1/79 1/80 1/81 1/82 1/83 1/84 1/85 1/86 1/87 1/88 1/89 1/90 1/91 1/92 1/93 1/94 1/95 1/96 1/97 1/98 1/99 1/100

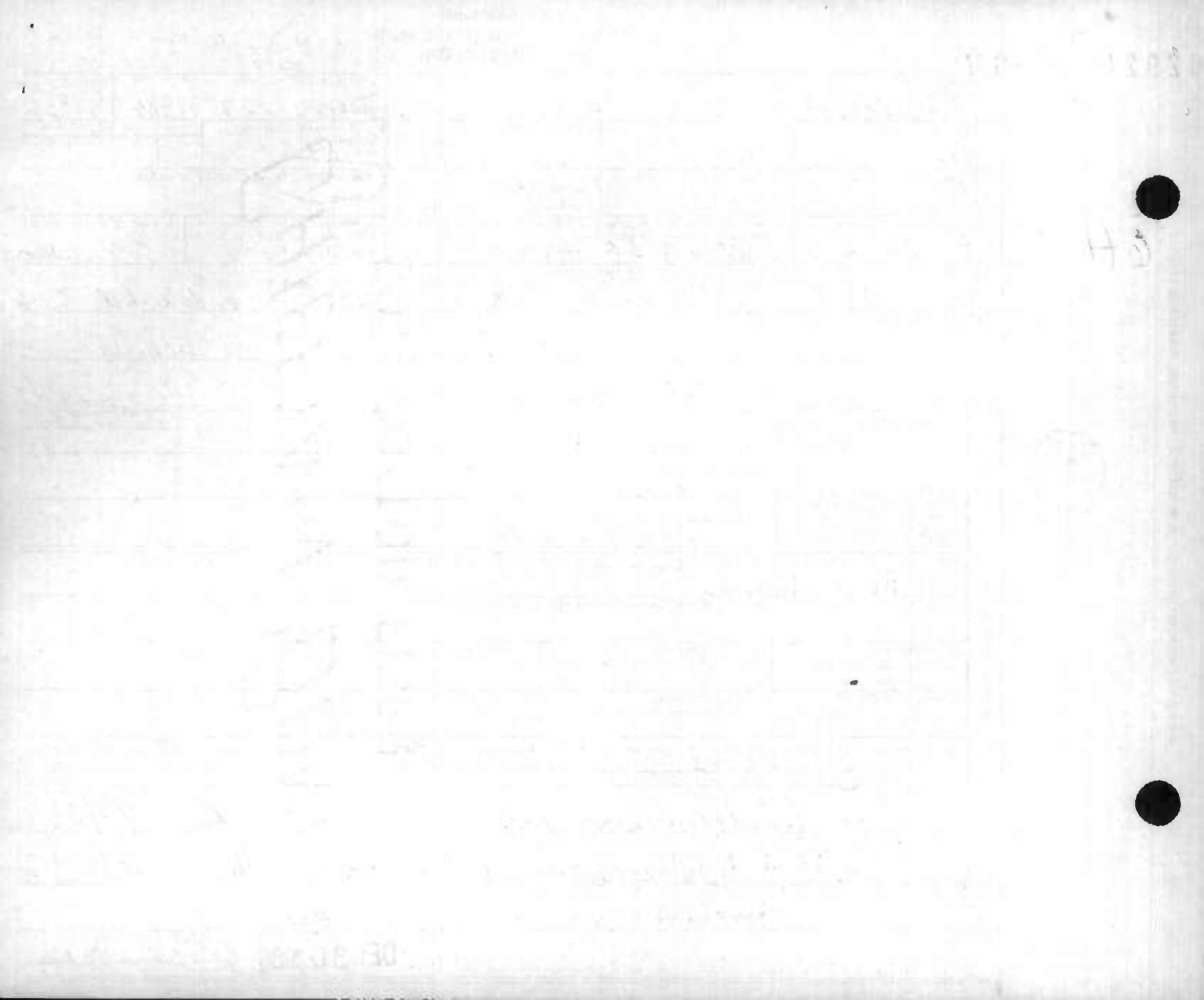
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return page 3 to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other condition, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|---|---|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Robert R Jones | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
Dec. 23 1986 | | 2b. HOUR
8:10 p.m. | |
| 3. SEX
M | 4. RACE
B | 5. DATE OF BIRTH
MONTH DAY YEAR
08 12 14 | | 6. AGE (IN YEARS LAST BIRTHDAY)
74 YRS | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Germany | 7b. CITIZEN OF WHAT COUNTRY?
US | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Loch Raven V.A. Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Construction | | 12b. KIND OF BUSINESS OR INDUSTRY
Construction | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Willie Jones | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ida Schools | | 13e. STREET ADDRESS / ZIP CODE
2318 Allendale Rd 71216 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
yes | | 16b. SOCIAL SECURITY NO.
218 14 4522 | | 17. INFORMANT
ADDRESS
Mary P. Jones 2318 Allendale Rd. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Uro sepsis
DUE TO, OR AS A CONSEQUENCE OF
(b) Cirrhosis
DUE TO, OR AS A CONSEQUENCE OF
(c) Chronic alcoholism
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
Renal Failure | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/1/86 , 19 86 , to 12/23 , 19 86 , that (I) (we) last saw the deceased alive on Dec 23 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Jeff Williamson MD | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12/23/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Jeff Williamson MD | | | | 22e. ADDRESS
Loch Raven V.A. Hospital Balto MD. | | | |
| 23a. (BURIAL) CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
12/29/86 | | 23c. NAME OF CEMETERY OR CREMATORY
Garrison Forest V.A. Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Owings Mills Md. | |
| 24. FUNERAL DIRECTOR
NAME
William C. March Funeral Home | | | | 25a. DATE RECD. BY REGISTRAR
DEC 30 1986 | | | |
| ADDRESS
4300 Wabash ave. | | | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | | |



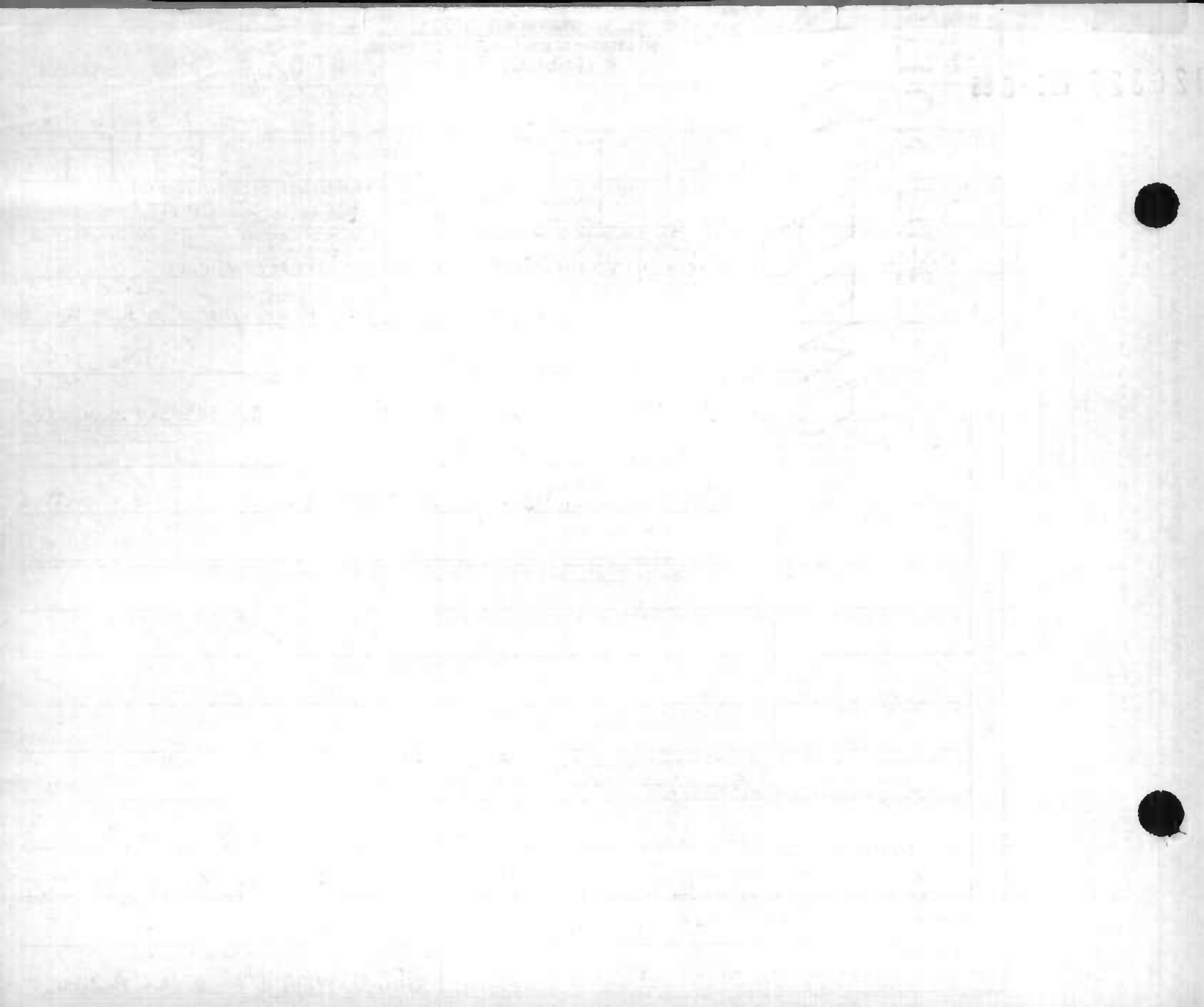
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 8034584 | | | |
|---|--|--|--|---|--|---|---|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH | | | |
| 10. DECEASED NAME
(TYPE OR PRINT) <u>William Jones</u> | | | | 12 2 86 655 AM | | | |
| 3. SEX
<u>Male</u> | | 4. RACE
<u>Black</u> | | 5. DATE OF BIRTH
MONTH DAY YEAR
<u>1 14 14</u> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<u>72</u> YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<u>S.C.</u> | | 7b. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<u>Baltimore City</u> MD. | |
| 10. CITY OR TOWN OF DEATH
<u>Balto.</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<u>1100 Pennsylvania Ave., Apt. 607</u> | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<u>Construction</u> | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
<u>MD</u> | | 13b. COUNTY | | 13c. CITY OR TOWN
<u>Balto.</u> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<u>Henry Jones</u> | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<u>Abbie Davis</u> | | 13e. STREET ADDRESS / ZIP CODE
<u>1100 Pennsylvania Ave. Apt 607</u> | | 21201 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) <u>Yes</u> | | 16b. SOCIAL SECURITY NO.
<u>705109314</u> | | 17. INFORMANT
<u>Geraldine B. Jones</u> | | ADDRESS
<u>1100 Pennsylvania Ave. Apt. 607</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>cardiac arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>perianapillary carcinoma</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>6 months</u> | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 18. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<u>P.M. 19</u> | | 21c. HOW INJURY OCCURRED
(ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 29</u> 19 <u>86</u> , to <u>Dec 1</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>Dec 1</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>Dorothy Snow</u> | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
<u>12/2/86</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>SNOW, DOROTHY</u> | | | | 22e. ADDRESS
<u>3900 Loch Raven Blvd. Balt.</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL
<u>BURIAL</u> | | 23b. DATE
<u>12-6-86</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>ARBUTUS CEM.</u> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<u>ARBUTUS MD</u> | |
| 24. FUNERAL DIRECTOR
NAME
<u>MARCH F/H 1101 E. NORTH AVE</u> | | | | 25a. DATE REC'D. BY REGISTRAR
<u>DEC 5 1986</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Julia Gordon-Randall</u> | |



029529 JAN

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86

34585

REG. NO.

FOR
STATE
REGISTRAR

| | | | | | | | | | | |
|---|--|---|--|---|--|--|---|--|-------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
William F Jones | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 28 86 | | | 2b. HOUR
129p | | | | |
| 3. SEX
M | | 4. RACE
B | | 5. DATE OF BIRTH
MONTH DAY YEAR
08 02 17 | | 6. AGE (IN YEARS LAST BIRTHDAY)
69 YRS | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE
(COUNTRY)
MD | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore City | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Sinai Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Disabled | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
MD | | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore City | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Lena Jones | | | 13e. STREET ADDRESS / ZIP CODE
3916 North 15 Ave 21216 | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | | 16b. SOCIAL SECURITY NO.
220-05-2383 | | 17. INFORMANT
Virgie Jones | | | | ADDRESS
526 N. Eutaw | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) Sepsis
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4 Hrs | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.
Squamous Cell Carc. Lung | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Robert K. Roby | | | DEGREE
MD | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
12/28/86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Robert K. Roby | | | 22e. ADDRESS
Sinai Hospital | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
1/3/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Eastview Cem | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore City | | | |
| 24. FUNERAL DIRECTOR
NAME
Wm. C. March Funeral Home | | | ADDRESS
1101 E. North Ave | | 25a. DATE REC'D. BY REGISTRAR
JAN 7 1987 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove card number 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician on page 1, it is to be filed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of the event.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 6 3 4 5 8 0 | | | |
|---|--|--|--|---|--|---|---|
| REG. NO. | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) CHARLES R JORDAN | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 13 86 | | 2b. HOUR
4:50 P | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
03-09-21 | | 6. AGE (IN YEARS LAST BIRTHDAY)
65 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
MERCY HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
MASTER MALHUSIST NAT'L CANK | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
— | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
PHILLIP WM. JORDAN | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MADELINE PALOSIK | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
220-05-2845 | | 17. INFORMANT
ADDRESS
ELVA JORDAN 7125 GRUNDY ST. 21224 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) LUNG CANCER WITH METASTASIS TO THE
DUE TO, OR AS A CONSEQUENCE OF
(b) BRAIN
DUE TO, OR AS A CONSEQUENCE OF
(c) — | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/01 , 19 86 , to 12/13 , 19 86 , that (I) (we) last saw the deceased alive on 12/13 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Michael Sylva | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12/13/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MICHAEL SYLVA | | 22e. ADDRESS
MERCY HOSPITAL 301 ST. PAUL ST. BALT. MD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
DEC 16, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY
GARDENS OF FAITH | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE MD | |
| 24. FUNERAL DIRECTOR
NAME
KILLY + ZEFILER INC. | | ADDRESS
700 S. CONKLING ST | | 25a. DATE REC'D. BY REGISTRAR
DEC 15 1986 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |

027542 DEB-15826

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | |
|--|---------|--|--------|--|-------------------------|---|---|---|--------------------------|----------|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 2a. DATE KNOWN OF DEATH | | <input checked="" type="checkbox"/> MONTH | DAY | YEAR | 2b. HOUR |
| Kenneth Ray Jordan, Sr. | | | | | 12/ 15/ 19 86 | | | | | A M |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | |
| Male | White | 6/21/35 | | 51 YRS. | MONTHS DAYS HOURS MIN. | | | | 12/ 15/ 19 86 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | |
| Md. | | USA | | | | Baltimore City, MD. | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Baltimore | | South Baltimore General Hospital | | | | Machinist | | Chem Metals | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | |
| Maryland | | | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 4224 Doris Ave., 21225 | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| Walter Lee Jordan, Sr. | | | | Emma Undutch | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | |
| No | | 220-30-4710 | | Kenneth R. Jordan, Jr. | | 1172 Newfield Ave. Balto. 21207 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | |
| IMMEDIATE CAUSE (a) _____ | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF _____ | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: _____ | | | | | | | | | | |
| (b) _____ | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF _____ | | | | | | | | | | |
| (c) _____ | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): | | | | | | | | | | |
| Diabetes Mellitus | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? | | |
| | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED | | (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY | | 21f. LOCATION | | | | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | (AT HOME, STREET, FACTORY, FARM, ETC.) | | STREET | | CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | | | DATE SIGNED | | | | |
| | | M.D. Assistant MEDICAL EXAMINER | | | | 12/15/86 | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | | | | | | | |
| Gregory R. Kauffman, M.D. | | 111 Penn St. | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | | |
| Burial | | 12/18/86 | | edar Hill Cemetery | | Balto., A. A. Co., Md. | | | | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | |
| McCully Funeral Homes | | 237 E. Patapsco Ave., Balto. Md. 21225 | | DEC 17 1986 | | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL, AND GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER WITH FORM 10. PAGES 1, 2, AND 3 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201. PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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(VR A15 ME (5))



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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 3 4 5 8 6

REG. NO.

| | | | | | |
|---|--|--|--|---|--|
| 1. DECEASED NAME
(LAST, FIRST, MIDDLE)
Joseph Joy | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 01 86 | | 2b. HOUR
1:45 PM | |
| 3. SEX
male | | 4. RACE
W | | 5. DATE OF BIRTH
MONTH DAY YEAR
10 11 1900 | |
| 6. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
MD | | 7b. CITIZEN OF WHAT COUNTRY?
MD | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SBCA | | 9. BALTIMORE CITY OR COUNTY OF DEATH
city | |
| 13a. STATE
MD | | 13b. CITY OR TOWN
AA | | 13c. STREET ADDRESS / ZIP CODE
405 Seventh Ave. Glen Burnie | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Harry Joy | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Alice Dean Joy | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | |
| 16b. SOCIAL SECURITY NO.
219073766 | | 17. INFORMANT
J. FRANK JOY, JR. | | ADDRESS
216 6th. Ave. N. Glen Burnie, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory & cardiac Rest
DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia (Staph. or strep)
DUE TO, OR AS A CONSEQUENCE OF (c) Recurrent UTI
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/2 19 86 to 12/1 19 86 , that (I) (we) lost
saw the deceased alive on 12/1 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
William J. Joy | | | | 22c. DATE SIGNED
12/1/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
William J. Joy | | | | 22e. ADDRESS
216 6th. Ave. N. Glen Burnie, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
12/5/86 | | 23c. NAME OF CEMETERY OR CREMATORY
NAZARENE CEMETERY | |
| 24. FUNERAL DIRECTOR
NAME
W. CLARKE MATTINGLEY, LEONARDTOWN, MD. | | 25a. DATE REC'D. BY REGISTRAR
DEC 8 1986 | | 25b. REGISTRAR'S SIGNATURE
Julia Darden-Randall | |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon (separate page) and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

100-21-10-022

100-21-10-022

100-21-10-022

100-21-10-022

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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3 4 5 8 9

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | | |
|--|--|---|--|---|--|--|---|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Almena Joyner | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 17 86 | | | 2b. HOUR
9 52 A.M. | | | | | |
| 3. SEX
Female | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
9 14 23 | | 6. AGE (IN YEARS (LAST BIRTHDAY))
63 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
USA | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Francis Scott Key Medical Center | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Nurse | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
Md. | | | 13b. COUNTY
Dundalk | | 13c. CITY OR TOWN
Turner station | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
409 Main St. | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Emery Brooks | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Alice Johnson | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | | 16b. SOCIAL SECURITY NO.
127-16-5973 | | 17. INFORMANT
Stanley Joyner | | | | ADDRESS
3710 Ferndale Rd | | |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Corduroy Lining Arrest
DUE TO, OR AS A CONSEQUENCE OF (b) Malignant Carcinoma of Colon
DUE TO, OR AS A CONSEQUENCE OF (c) Hypertensive Cardiovascular Disease. | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a-c) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED
(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from May 19 85, to December 17, 19 86, that (we) last saw the deceased alive on December 12, 19 86, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Noel E. McCall MD. | | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
December 30, 86 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Noel E. McCall, MD. | | | | | | 22e. ADDRESS
Francis Scott Key Medical Center, Balt. Md 21224 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
12-22-86 | | 23c. NAME OF CEMETERY OR CREMATORY
Balt. National | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore City Md. | | | | |
| 24. FUNERAL DIRECTOR
NAME
James A. Morton & Sons | | | | | | ADDRESS
1701 Laurens | | 25a. DATE REC'D. BY REGISTRAR
DEC 23 1986 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | |

MEDICAL CERTIFICATION



28699 DEC 31 1986

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 3 4 5 9 0

REG. NO.

| | | | | | | | | | | | |
|---|--|---|--|---|-----------------------------|--|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
CATHERINE E. JUBB | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 28 86 | | | 2b. HOUR
6:40 AM | | | | | |
| 3. SEX
F | | 4. RACE
W | | 5. DATE OF BIRTH
MONTH DAY YEAR
11 - 11 - 1892 | | 6. AGE (IN YEARS LAST BIRTHDAY)
94 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | | | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
MD. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTO. CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
BALTO. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
FRANCIS SCOTT KEY M.C. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK OR MOST OF WORKING LIFE)
RETIRED | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MD. | | | 13b. COUNTY | | 13c. CITY OR TOWN
BALTO. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
110 S. EATON ST. 21224 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
FRANK ENSOR | | | 15. MOTHER'S MAIDEN NAME
MIDDLE LAST
MARY BASSLER | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | | 16b. SOCIAL SECURITY NO.
219-07-0016 | |
| 17. INFORMANT
ADDRESS
21224 | | | 17. INFORMANT
MARGARET K. KELCH 228 S. BOULDER ST. | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) hypoxia.
DUE TO, OR AS A CONSEQUENCE OF
(b) pneumonia.
DUE TO, OR AS A CONSEQUENCE OF
(c)
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a. | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (this hospital) attended the deceased from 12/27/86 to 12/28/86, that (we) last saw the deceased alive on 12/28/86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
P.L. Cronin MD | | | DEGREE | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED
12/28/86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
P.L. CRONIN | | | 22e. ADDRESS
FSK HOSPITAL | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(CITY)
BURIAL | | | 23b. DATE
12-30-86 | | | 23c. NAME OF CEMETERY OR CREMATORY
DARLAWN CEM. | | | 23d. LOCATION
CITY OR TOWN COUNTY
BALTO. MD. | | |
| 24. FUNERAL DIRECTOR
HOFFMANN-SKARDA 3218 HUDSON ST. | | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 30 1986 | | 25b. REGISTRAR'S SIGNATURE
F. J. J. J. | | | |

MEDICAL CERTIFICATION

2
9

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified above.

BP

DHMH - 16 50M 4/83
(VRA 15, 4)

City of
San Francisco

San Francisco
California

San Francisco
California

129029 JAN - 5 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 3 4 5 9 1

REG. NO.

| | | | | | | | | | | |
|--|--|--|---|--|--|--|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Justin Allen Boone Judd | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 16 86 | | | 2b. HOUR
9:26 PM | | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
12 13 86 | | 6. AGE (IN YEARS LAST BIRTHDAY)
3 days YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
3 | | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
US Maryland | | 9. CITIZEN OF WHAT COUNTRY?
US | | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 11. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | |
| 12. CITY OR TOWN OF DEATH
Baltimore | | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
U of Maryland | | 14. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
none | | 15. KIND OF BUSINESS OR INDUSTRY
----- | | | | |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | 13b. COUNTY
Washington | | 13c. CITY OR TOWN
Williamsport | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
Rt. 1 Bx# 269 21795 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Todd Allen Judd | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Christina Dianne Boone | | | 16. ADDRESS | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
none | | 17. INFORMANT
Christina Boone | | 17. ADDRESS
(item 13 above) | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) cerebral dysfunction
DUE TO, OR AS A CONSEQUENCE OF
(b) congenital hydrocephalus
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 days | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/15, 19 86, to 12/16, 19 86, that (I) (we) last saw the deceased alive on 12/16, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Rose Marie Viscardi MD | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
12/16/86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Rose Marie Viscardi MD | | | | | 22e. ADDRESS
SSAIO University of Maryland Hospital | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
burial | | | 23b. DATE
Dec. 19, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY
Greenlawn Memorial Pk | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Williamsport Washington Maryland | | | |
| 24. FUNERAL DIRECTOR
NAME
Major M. Osborne Williamsport, MD 21795 | | | | | | | | | | |

35
38
210
2
1
2

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DEC 29 1986

Julia Anderson-Rodriguez

1. The first part of the report is a general description of the project and its objectives. It is followed by a detailed description of the methods used in the study.

2. The second part of the report is a description of the results of the study. It is followed by a discussion of the results and their implications.

3. The third part of the report is a conclusion. It is followed by a list of references and a list of figures.

4. The fourth part of the report is a list of references. It is followed by a list of figures.

5. The fifth part of the report is a list of figures. It is followed by a list of references.

6. The sixth part of the report is a list of references. It is followed by a list of figures.

100% COTTON BLEND

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | | |
|---|--|--|---|---|----------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
ELEANORE R. JUGO | | | 2a. DATE OF DEATH
MONTH DAY YEAR
DEC. 30, 1986 | | 2b. HOUR
10:15AM | |
| 3. SEX
FEMALE | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH
MONTH DAY YEAR
FEB. 22, 1927 | | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
59 YRS. | | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 8. IF UNDER 1 YEAR
MONTHS DAYS
59 | | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY | | 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
1818 GOUGH STREET | | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
CLERK TYPIST | | 12b. KIND OF BUSINESS OR INDUSTRY
Soc. Security | | 13a. STREET ADDRESS
1818 GOUGH STREET 21231 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
JOHN LOWINSKI | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
JOANNA ZAJAC | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | |
| 16b. SOCIAL SECURITY NO.
216-20-4249 | | 17. INFORMANT
FRANK JUGO | | 18. ADDRESS
1818 GOUGH ST. 21231 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) METASTATIC BLADDER CA
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED
(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6-27 , 19 87 , to 9-29 , 19 86 , that (I) (we) lost saw the deceased alive on 11-15 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
H. O. Ph.D. | | | | 22c. DATE SIGNED
12-31-86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
WRIESENDRUP H.M. M.D. | | | | 22e. ADDRESS
600 N WOLF STREET BALTO MD | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
1/2/87 | | 23c. NAME OF CEMETERY OR CREMATORY
ST. STANISLAUS CEMETERY | | |
| 23d. LOCATION
CITY OR TOWN
BALTIMORE | | 23e. COUNTY
MARYLAND | | 23f. STATE | | |
| 24. FUNERAL DIRECTOR
NAME
George A. Weber & Sons Inc. | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 31 1986 | | |
| 25b. REGISTRAR'S SIGNATURE
John E. ... | | | | 25c. ADDRESS
705 S. Ann St. 21231 | | |

026177 DEC 15 1986

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6

3 4 5 9 3

REG. NO.

| | | | | | | | | | |
|---|--|--|--|---|--|--|-----------------------------------|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
<i>Rosemary Kagle</i> | | | 2a. DATE OF DEATH
MONTH DAY YEAR
<i>Dec. 1, 1986</i> | | 2b. HOUR
<i>3:30 PM</i> | | | | |
| 3. SEX
<i>Female</i> | | 4. RACE
<i>White</i> | | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>Mar. 27, 1922</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>64</i> YRS.
IF UNDER 1 YEAR: MONTHS DAYS
IF UNDER 24 HRS: HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>Maryland</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Baltimore City</i> MD. | | | |
| 10. CITY OR TOWN OF DEATH
<i>Baltimore</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Mercy Hospital, Balto. Md.</i> | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Homemaker</i> | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE
<i>Maryland</i> | | 13b. COUNTY
<i>---</i> | | 13c. CITY OR TOWN
<i>Baltimore</i> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
<i>1800 Light St. Balto. Md. 21230</i> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>Leo E. Collins</i> | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>Matilda --- Moran</i> | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>No</i> | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
<i>216-12-8889</i> | | 17. INFORMANT
ADDRESS
<i>Anita E. Wilkinson, 210 Sipple Ave. Balto. Md. 21236</i> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>RENAL FAILURE</i>
DUE TO, OR AS A CONSEQUENCE OF (b) <i>OBSTRUCTIVE LUNG DISEASE</i>
DUE TO, OR AS A CONSEQUENCE OF (c) <i>CONGESTIVE HEART FAILURE</i>
Approximate interval between onset and death:
<i>1 YEAR</i>
<i>2 YEARS</i>
<i>3 YEARS</i> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<i>11-30 P.M. 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (i) (this hospital) attended the deceased from <i>11-30</i> 19 <i>86</i> , to <i>12-1</i> 19 <i>86</i> , that (i) (we) saw the deceased <i>above</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (i) (we) (did) (did not) show the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<i>[Signature]</i> | | DEGREE
<i>MD</i> | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<i>12/1/86</i> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>MAVC S. POWELL</i> | | 22e. ADDRESS
<i>107 F. WEST ST.</i> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<i>Burial</i> | | 23b. DATE
<i>12/5/1986</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Cedar Hill Cemetery</i> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Balto. A.A. Co. Md.</i> | | | |
| 24. FUNERAL DIRECTOR
NAME
<i>McCully Funeral Home, 130 E. Fort Ave. Balto. Md. 21230</i> | | | | 25a. DATE REC'D. BY REGISTRAR
<i>DEC 4 1986</i> | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | |

MEDICAL CERTIFICATION

99

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

1. The first part of the report deals with the general situation of the project. It is noted that the project has been completed and that the results are satisfactory. The second part of the report deals with the specific details of the project. It is noted that the project was completed on time and that the results are satisfactory. The third part of the report deals with the conclusions of the project. It is noted that the project was completed on time and that the results are satisfactory. The fourth part of the report deals with the recommendations of the project. It is noted that the project was completed on time and that the results are satisfactory. The fifth part of the report deals with the summary of the project. It is noted that the project was completed on time and that the results are satisfactory.

10-20-50

6349 DEC -8 86
0263491- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

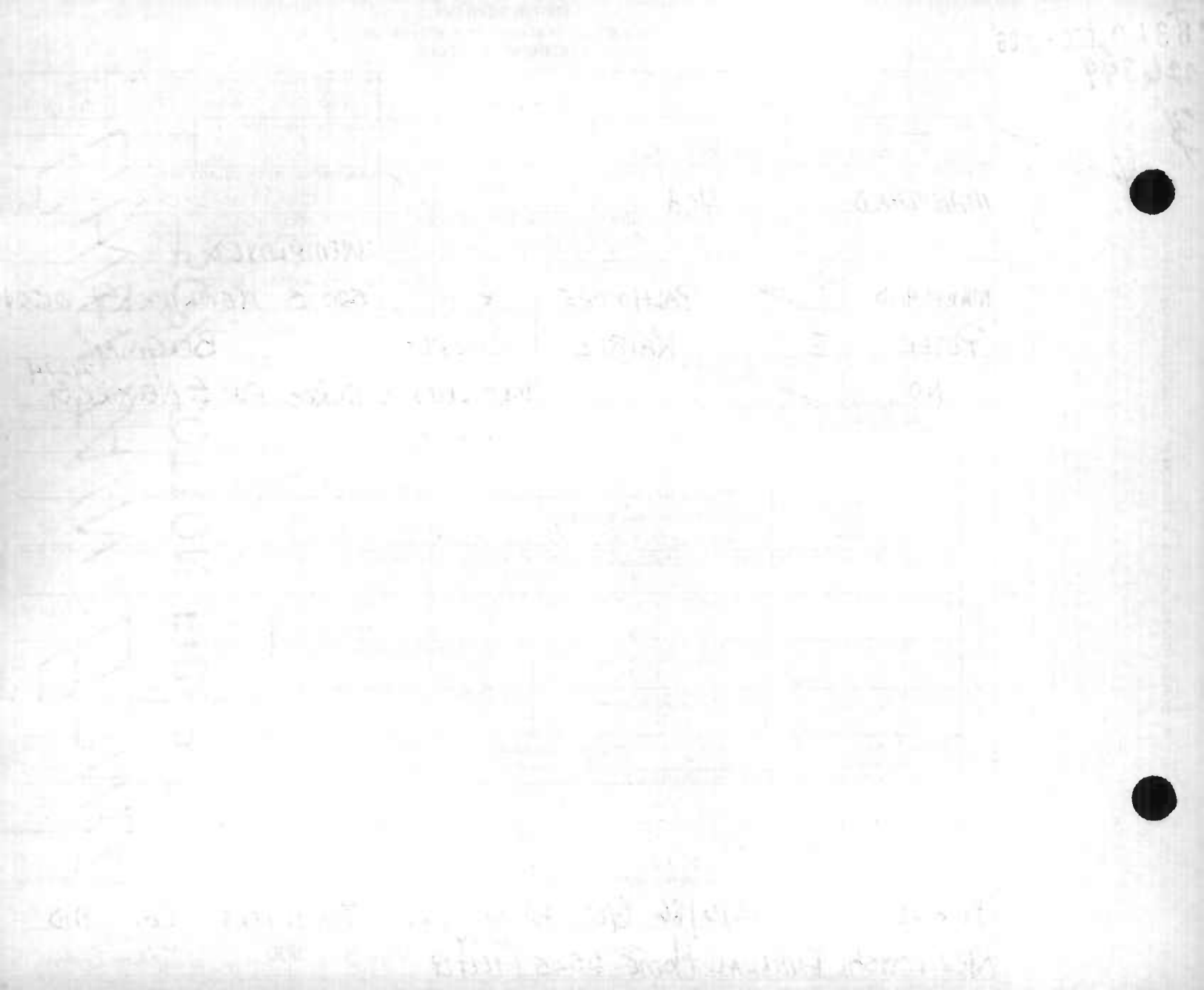
REG. NO.

| | | | | | | | | | | |
|---|--|---|--|---|---|--|--|--|--------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
CAROLYN KAIROS | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 - 3 - 86 | | | 2b. HOUR
5:18 PM | | | | |
| 3. SEX
Female | | 4. RACE
white | | 5. DATE OF BIRTH
MONTH DAY YEAR
4 29 60 | | 6. AGE (IN YEARS LAST BIRTHDAY)
26
YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
frances scott Key Med Cent | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
UNEMPLOYED | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
MARYLAND | | | 13b. CITY OR TOWN
BALTIMORE | | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS / ZIP CODE
620 S. NEWKIRK ST. 21224 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
PETER E KAIROS | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
DELORES BERGMAN | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | | 16b. SOCIAL SECURITY NO. | |
| 17. INFORMANT
ADDRESS
MRS DELORES KAIROS 520 S. NEWKIRK ST. 21224 | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Hepatic failure</u>
DUE TO, OR AS A CONSEQUENCE OF:
(b) <u>Hepatitis B infection</u>
DUE TO, OR AS A CONSEQUENCE OF:
(c) <u>Drug Addict - IV</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12-1-86</u> , 19 <u>86</u> , to <u>12-3-86</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>12-3-86</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Grace A. Cordts MD | | | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
12-3-86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Grace A. CORDTS | | | | | | 22e. ADDRESS
FSK MC Baltimore, Md | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | | 23b. DATE
12/6/86 | | 23c. NAME OF CEMETERY OR CREMATORY
GLEN HAVEN Cem | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE Co. MD | | | |
| 24. FUNERAL DIRECTOR
NAME
Kaczorowski FUNERAL Home | | | | | | ADDRESS
21224 5225 Heets | | 25a. DATE REC'D. BY REGISTRAR
DEC 5 1986 | | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE
Julia Anderson-Rudner | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked for item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



027878 DE 13 1986

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | |
|--|--|---|---|---|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
JOHN Henry KALBFLEISCH | | | 2a. DATE OF DEATH
MONTH DAY YEAR
DECEMBER 21, 1986 | | 2b. HOUR
1:00 P.M. | | | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
DAY MONTH YEAR
4 15 1910 | | 6. AGE (IN YEARS LAST BIRTHDAY)
76 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN FICHH FACILITY, GIVE STREET ADDRESS)
Church Hospital Inc. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Manager | | 12b. KIND OF BUSINESS OR INDUSTRY
Retail Jewelry | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Dundalk | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
2478 Keyway / 21222 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Joseph Kalbfleisch | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary (Unknown) | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
212/07/2854 | | 17. INFORMANT ADDRESS
Mildred V. Kalbfleisch (same as 13e.) | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CANCER OF LUNG
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (we) (this hospital) attended the deceased from DECEMBER 13, 1986 to DECEMBER 21, 1986 , that (we) last saw the deceased alive on DECEMBER 21, 1986 , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<i>A. Nazemi</i> | | | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
12/21/86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
A. NAZEMI | | | | | | 22e. ADDRESS
100 N. Broadway Balto, Md 21231 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
12/24/1986 | | 23c. NAME OF CEMETERY OR CREMATORY
Oak Lawn Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Maryland 21224 | | | |
| 24. FUNERAL DIRECTOR
NAME
Walter Brooks Bradley Inc. Balto., Md. 21222 | | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 22 1986 | | 25b. REGISTRAR'S SIGNATURE
<i>Julia Davidson-Randall</i> | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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026559 DEC 10

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0 3 4 3 7 0

REG. NO.

| | | | | | |
|--|---|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
ALBERT A. KAMOSA | | | 2a. DATE OF DEATH
MONTH DAY YEAR
December 5, 1986 | | 2b. HOUR
M
M |
| 1. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
Feb., 11, 1919 | | 6. AGE (IN YEARS LAST BIRTHDAY)
67 YRS. | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
 |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
6104 Bertram Avenue | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Lithographer | 12b. KIND OF BUSINESS OR INDUSTRY
Printing | |
| 13a. STATE
Maryland | 13b. COUNTY
 | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
6104 Bertram Avenue 21214 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John Kamosa | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Barbara Diddlemeyer | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
212-01-0709 | | 17. INFORMANT
ADDRESS
Mrs. Dorothy L. Kamosa same as 13e | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) COPD end stage
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
 |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION
2/9 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
 | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Stanley A. Morrison, M.D. | | | | 22c. DATE SIGNED
12/5/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Stanley A. Morrison, M.D. | | | | 22e. ADDRESS
5601 Loch Raven Blvd. Suite 102 | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
12/9/1986 | 23c. NAME OF CEMETERY OR CREMATORY
Most Holy Redeemer | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore City, Maryland | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Leonard J. Ruck, Inc. 5305 Harford Road 21214 | | | 25a. DATE REC'D. BY REGISTRAR
DEC 8 1986 | | |
| | | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove contents of pages 1 and 2, and 3, and 4, and 5, and 6, and 7, and 8, and 9, and 10, and 11, and 12, and 13, and 14, and 15, and 16, and 17, and 18, and 19, and 20, and 21, and 22, and 23, and 24, and 25, and 26, and 27, and 28, and 29, and 30, and 31, and 32, and 33, and 34, and 35, and 36, and 37, and 38, and 39, and 40, and 41, and 42, and 43, and 44, and 45, and 46, and 47, and 48, and 49, and 50, and 51, and 52, and 53, and 54, and 55, and 56, and 57, and 58, and 59, and 60, and 61, and 62, and 63, and 64, and 65, and 66, and 67, and 68, and 69, and 70, and 71, and 72, and 73, and 74, and 75, and 76, and 77, and 78, and 79, and 80, and 81, and 82, and 83, and 84, and 85, and 86, and 87, and 88, and 89, and 90, and 91, and 92, and 93, and 94, and 95, and 96, and 97, and 98, and 99, and 100, and 101, and 102, and 103, and 104, and 105, and 106, and 107, and 108, and 109, and 110, and 111, and 112, and 113, and 114, and 115, and 116, and 117, and 118, and 119, and 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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 3 4 5 9 7

REG. NO.

FOR
STATE
REGISTRAR

| | | | | | |
|--|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
MICHAEL RALPH KANE | | 2a. DATE OF DEATH
MONTH DAY YEAR
12/19/86 | | 2b. HOUR
M
 | |
| 3. SEX
M | 4. RACE
B | 5. DATE OF BIRTH
MONTH DAY YEAR
11/4/32 | | 6. AGE (IN YEARS LAST BIRTHDAY)
54
YRS MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Balto., Md. | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Balto., City MD | |
| 10. CITY OR TOWN OF DEATH
Balto. | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
3720 Nortonia Rd. 21216 | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
retired | | 12b. KIND OF BUSINESS OR INDUSTRY
 |
| 13a. STATE
Md. | | 13b. COUNTY
 | 13c. CITY OR TOWN
Balto. | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Philip M. Kane | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary P. Gough | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WWII | | 17. INFORMANT
ADDRESS
Lucille Diana Kane 3720 Nortonia Rd. | |

| | | |
|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarction
DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic Heart Disease
DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerosis | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE |
|---|--|--|

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **NA**

| | | | |
|--|--|---|--|
| 19a. DATE OF OPERATION
/ | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
/ | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)
/ | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
/ | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
/ | |
| 22a. I certify that (I) (this hospital) attended the deceased from 05/24/86 to 12/19/86 , that (I) (we) lost 12/22/86
saw the deceased last on 12/19/86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. | | | |
| 22b. SIGNATURE
HARRY M. WALEN, M.D. | | DEGREE
MD
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED
12/22/86 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
HARRY M. WALEN, M.D. | | 22e. ADDRESS
10807 Falls Rd Lutherville, Md. 21093 | |

| | | | |
|--|------------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | 23b. DATE
12/23/86 | 23c. NAME OF CEMETERY OR CREMATORY
Garrison Forest | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Owings Mill, Md. |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Leroy O. Dyett 4600 Liberty Heights | | 25a. DATE REC'D. BY REGISTRAR
DEC 21 1986 | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the registrar, it should be detached for use as the burial-transit permit. Then please return it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

0500170050



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The certificate must be carbon-copied. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

228073 DEC 19 1986

FOR
REGISTRAR

#1, Film G659 1/24/90 kam

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|--|---|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Edith Helen Ev Kearney | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12-16-86 | | | 2b. HOUR
2:01A M | | | |
| 3. SEX
F | | 4. RACE
B | | 5. DATE OF BIRTH
MONTH DAY YEAR
10-28-07 | | 6. AGE (IN YEARS LAST BIRTHDAY)
79 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Balto. City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Balto. City | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
St. Agnes Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
MD | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Jestus Williams | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Fannie Drinkwater | | 16. STREET ADDRESS / ZIP CODE
1623 N. Caroline St. 21213 | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
099-03-6961 | | 17. INFORMANT ADDRESS
William H. Kearney 1623 N. Caroline St. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Acute & healing myocardial infarct</i>
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Coronary atherosclerosis</i>
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Diabetes mellitus</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>11/14</i> 19 <i>86</i> , to <i>12/16</i> 19 <i>86</i> , that (I) (we) lost saw the deceased alive on <i>12/16</i> 19 <i>86</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<i>M. Maciulis / W.J. Hicken</i> | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
<i>12/16/86</i> | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>M. MACIULIS / W.J. HICKEN</i> | | 22e. ADDRESS
<i>ST. AGNES HOSPITAL</i> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
12/20/86 | | 23c. NAME OF CEMETERY OR CREMATORY
Arbutus Memorial Pk. | | 23d. LOCATION
Arbutus | | COUNTY MD | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Wm. C. March F/H, Inc. 1101 E. North Ave. | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 21 1986 | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | |

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 3 4 5 9 9

REG. NO.

| | | | | | | | |
|--|--|--|--|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
MARTIN Edward Keemer | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 24 86 | | | 2b. HOUR
11:45 AM | |
| 3. SEX
MALE | | 4. RACE
BLACK | | 5. DATE OF BIRTH
MONTH DAY YEAR
10 09 37 | | 6. AGE (IN YEARS LAST BIRTHDAY)
49 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Baltimore, MD | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore C.T. MD | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Deaton Hospital & Medical Center | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
CONSTRUCTION | |
| 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| 13a. STATE
MD | | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | |
| 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS / ZIP CODE
5120 Laurel Ave 21245 | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
DANIEL JOHNSON | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MARY L. KEEMER | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
yes | | | 16b. SOCIAL SECURITY NO.
216-32-0945 | | 17. INFORMANT
ADDRESS
KATHY L. PERRY 5120 Laurel Ave | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CAEDIO PULMONARY ARREST
DUE TO, OR AS A CONSEQUENCE OF
(b) METASTATIC SQUAMOUS CELL CARCINOMA OF THE TONGUE
DUE TO, OR AS A CONSEQUENCE OF
(c) OF THE TONGUE
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3-21 | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: none | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
12/19/86 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
CB | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
12/24 | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
120 S. GREENE ST. BALT, MD 21021 | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/19/86 to 12/24/86 , that (I) (we) last saw the deceased alive on 12/24 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
G. A. Hopper, MD | | DEGREE
MD | | | | 22c. DATE SIGNED
12/24/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
GAYLE A. Hopper, MD | | 22e. ADDRESS
DEATON MED CENTER
120 S. GREENE ST. BALT, MD 21021 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
12/29/86 | | 23c. NAME OF CEMETERY OR CREMATORY
MD VETERANS | | 23d. LOCATION
(CITY OR TOWN) COUNTY STATE
Baltimore MD MD | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Mr. J. J. Jones 636 N. G. / Mon St | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 29 1986 | | 25b. REGISTRAR'S SIGNATURE
Davidson-Randall | |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of case.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

027854 DEC 23 1986

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 3 4 6 0 0

REG. NO.

| | | | | | | |
|---|--|--|---|---|---------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
JAMES EARL KEENE | | | 2a. DATE OF DEATH
MONTH DAY YEAR
DECEMBER 18, 1986 | | 2b. HOUR
12:44A | |
| 3. SEX
Male | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
May 19, 1902 | | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS MONTHS DAYS
84 | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE JOHNS HOPKINS HOSPITAL | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY | | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Longshoreman | | 12b. KIND OF BUSINESS OR INDUSTRY
Retired | | 13a. STREET ADDRESS / ZIP CODE
936 N. Washington St. 21205 | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Oliver Keene | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Sarah Keene | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | |
| 16b. SOCIAL SECURITY NO.
214-05-1291 | | 17. INFORMANT
Harold Earl Keene | | ADDRESS
936 N. Washington St. 21205 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST
DUE TO, OR AS A CONSEQUENCE OF (b) MULTIPLE RESPIRATORY ARREST
DUE TO, OR AS A CONSEQUENCE OF (c) PROBABLE BRAIN STEM ISCHEMIA
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
30 min.
2 days
2 days | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
① NO MYOCARDIAL INFARCTS ② PROSTATIC CARCINOMA | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 12/16/1986 to 12/18/1986 , that (I) (we) last saw the deceased alive on 12/18/1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
ALKIS G. TOGIAS | | DEGREE
M.D. | | 22c. DATE SIGNED
12/18/86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ALKIS G. TOGIAS | | 22e. ADDRESS
JOHNS HOPKINS HOSPITAL | | 22f. DATE REC'D. BY REGISTRAR
DEC 22 1986 | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
12-23-86 | | 23c. NAME OF CEMETERY OR CREMATORY
Arbutus Memorial Park | | |
| 24. FUNERAL DIRECTOR
NAME
Marshall W. Jones, Jr. | | ADDRESS
4101 Edmondson Ave. | | 25a. DATE REC'D. BY REGISTRAR
DEC 22 1986 | | |
| 25b. REGISTRAR'S SIGNATURE
Julia Tisdem-Ridgely | | | | | | |

DIVISION OF VITAL RECORDS, 201 W. FAYETTE ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed with facts known after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the funeral director. Page 4 should be retained by the funeral director. Page 5 should be retained by the funeral director. Page 6 should be retained by the funeral director. Page 7 should be retained by the funeral director. Page 8 should be retained by the funeral director. Page 9 should be retained by the funeral director. Page 10 should be retained by the funeral director. Page 11 should be retained by the funeral director. Page 12 should be retained by the funeral director. Page 13 should be retained by the funeral director. Page 14 should be retained by the funeral director. Page 15 should be retained by the funeral director. Page 16 should be retained by the funeral director. Page 17 should be retained by the funeral director. Page 18 should be retained by the funeral director. Page 19 should be retained by the funeral director. Page 20 should be retained by the funeral director. Page 21 should be retained by the funeral director. Page 22 should be retained by the funeral director. Page 23 should be retained by the funeral director. Page 24 should be retained by the funeral director. Page 25 should be retained by the funeral director. Page 26 should be retained by the funeral director. Page 27 should be retained by the funeral director. Page 28 should be retained by the funeral director. Page 29 should be retained by the funeral director. Page 30 should be retained by the funeral director. Page 31 should be retained by the funeral director. Page 32 should be retained by the funeral director. Page 33 should be retained by the funeral director. Page 34 should be retained by the funeral director. Page 35 should be retained by the funeral director. Page 36 should be retained by the funeral director. Page 37 should be retained by the funeral director. Page 38 should be retained by the funeral director. Page 39 should be retained by the funeral director. Page 40 should be retained by the funeral director. Page 41 should be retained by the funeral director. Page 42 should be retained by the funeral director. Page 43 should be retained by the funeral director. Page 44 should be retained by the funeral director. Page 45 should be retained by the funeral director. Page 46 should be retained by the funeral director. Page 47 should be retained by the funeral director. Page 48 should be retained by the funeral director. Page 49 should be retained by the funeral director. Page 50 should be retained by the funeral director. Page 51 should be retained by the funeral director. Page 52 should be retained by the funeral director. Page 53 should be retained by the funeral director. Page 54 should be retained by the funeral director. Page 55 should be retained by the funeral director. Page 56 should be retained by the funeral director. Page 57 should be retained by the funeral director. Page 58 should be retained by the funeral director. Page 59 should be retained by the funeral director. Page 60 should be retained by the funeral director. Page 61 should be retained by the funeral director. Page 62 should be retained by the funeral director. Page 63 should be retained by the funeral director. Page 64 should be retained by the funeral director. Page 65 should be retained by the funeral director. Page 66 should be retained by the funeral director. Page 67 should be retained by the funeral director. Page 68 should be retained by the funeral director. Page 69 should be retained by the funeral director. Page 70 should be retained by the funeral director. Page 71 should be retained by the funeral director. Page 72 should be retained by the funeral director. Page 73 should be retained by the funeral director. Page 74 should be retained by the funeral director. Page 75 should be retained by the funeral director. Page 76 should be retained by the funeral director. Page 77 should be retained by the funeral director. Page 78 should be retained by the funeral director. Page 79 should be retained by the funeral director. Page 80 should be retained by the funeral director. Page 81 should be retained by the funeral director. Page 82 should be retained by the funeral director. Page 83 should be retained by the funeral director. Page 84 should be retained by the funeral director. Page 85 should be retained by the funeral director. Page 86 should be retained by the funeral director. Page 87 should be retained by the funeral director. Page 88 should be retained by the funeral director. Page 89 should be retained by the funeral director. Page 90 should be retained by the funeral director. Page 91 should be retained by the funeral director. Page 92 should be retained by the funeral director. Page 93 should be retained by the funeral director. Page 94 should be retained by the funeral director. Page 95 should be retained by the funeral director. Page 96 should be retained by the funeral director. Page 97 should be retained by the funeral director. Page 98 should be retained by the funeral director. Page 99 should be retained by the funeral director. Page 100 should be retained by the funeral director.

FOR STATE REGISTRAR
JAMES EARL KEENE
12-23-86

15

0011006 100 570-27-01

30. *Woolfson, D. M.*

31113

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**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH**

8 6 3 4 6 0 1

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | |
|---|--|---|--|---|--|---|--|--|---|--|
| DECEASED NAME
(TYPE OR PRINT)
Rose | | FIRST
Keeney | | LAST | | 2a. DATE OF DEATH
MONTH DAY YEAR
12-26-86 | | | 2b. HOUR
1:15 P_M | |
| 3. SEX
female | | 4. RACE
white | | 5. DATE OF BIRTH
MONTH DAY YEAR
10-20-1892 | | 6. AGE (IN YEARS LAST BIRTHDAY)
94
YRS MONTHS DAYS | | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Balto., MD | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City
MD | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore City | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Edgewood Nursing Home | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Home Maker | | | 12b. KIND OF BUSINESS OR INDUSTRY | |

| | | | | | | | | | | |
|-------------------------|--|-------------|--|---|--|---|--|---|--|--|
| 13a. STATE
MD | | 13b. COUNTY | | 13c. CITY OR TOWN
Balto. City | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
3227 Dudley Ave., Balto. 21213 | | |
|-------------------------|--|-------------|--|---|--|---|--|---|--|--|

| | | | |
|---|--|---|--|
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Frank Long | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | |
|---|--|---|--|

| | | | | | |
|---|--|--|--|--|--|
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO.
MA 784803
217-84-0340 | | 17. INFORMANT
ADDRESS
Calvin E. Keeney, Sr., 3227 Dudley Ave. 21213 | |
|---|--|--|--|--|--|

| | | | |
|--|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CVA | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | (b) hypertension | |
| DUE TO, OR AS A CONSEQUENCE OF | | (c) | |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **1**

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
12/19/86
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
5218 Springlake Way Brook Md | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/19/86 to 12/26/86 that (I) (we) last saw the deceased alive on 12/19/86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<i>C. Bessent</i> | | | | | | 22c. DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
C. Bessent | | | | | | 22e. ADDRESS
5218 Springlake Way Brook Md | |

| | | | | | | | |
|---|--|------------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
12-29-86 | | 23c. NAME OF CEMETERY OR CREMATORY
Oak Lawn Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto. MD | |
|---|--|------------------------------|--|--|--|--|--|

| | | | | | |
|---|--|---|--|---|--|
| 24. FUNERAL DIRECTOR
John C. Miller, Inc., 6415 Belair Rd., 21206 | | 25a. DATE REC'D. BY REGISTRAR
DEC 29 1986 | | 25b. REGISTRAR'S SIGNATURE
<i>Julia Gordon-Randall</i> | |
|---|--|---|--|---|--|

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial transit permit. Then please inform the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the Medical Examiner must be notified and advised.

FOR COTTON FIBRE

MADE IN
CHINA

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6

3 4 6 0 2

REG. NO.

| | | | | | | | | | | | |
|---|--|--|--|---|---|--|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) CHARLES E KEISER Jr | | | 2a. DATE OF DEATH
MONTH 12 DAY 15 YEAR 86 | | | 2b. HOUR
5:25 A.M. | | | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH 4 DAY 10 YEAR 12 | | 6. AGE (IN YEARS LAST BIRTHDAY)
74 YRS. | | IF UNDER 1 YEAR
MONTHS 0 DAYS 0 | | IF UNDER 72 HRS
HOURS 0 MIN. 0 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALT. CITY. MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
BALT. CITY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SOUTH BALT. GEN. HOSP. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
RETIRED | | 12b. KIND OF BUSINESS OR INDUSTRY
Truck Driver | | | |
| 13a. STATE
MD. | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
209 BRIGHT | | 13f. 114 E. Barney St. Balt. MD 21230 | |
| 14. FATHER'S NAME
FIRST UNK. MIDDLE Charles E. LAST Keiser, Sr. | | | | 15. MOTHER'S MAIDEN NAME
FIRST UNK. MIDDLE LAST | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO.
003949271 | | 17. INFORMANT CHART, Lorraine Sterling. ADDRESS 21122 1882 Potomac Rd. Pasadena | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DUE TO, OR AS A CONSEQUENCE OF
(b) PULMONARY EMBOLISM | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/26 19 86 , to 12/15 19 86 , that (I) (we) last saw the deceased alive on 12/15 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
G. Weiss | | | DEGREE MD | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
12/15/86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
G. WEISS | | | 22e. ADDRESS
3001 S. HANOVER ST, BALTO, MD. | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
12/18/86 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemt. | | | 23d. LOCATION
CITY OR TOWN BALTO. COUNTY A.A. STATE Co. Md. | | | |
| 24. FUNERAL DIRECTOR Balto. Md. 21230
NAME McCurly Funeral Home ADDRESS 130 E. Fort Ave. | | | | | | 25a. DATE REC'D. BY REGISTRAR DEC 17 1986 SIGNATURE Julia Gordon-Rodman | | | | | |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic or medical examiner must be notified of same.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove copies of pages 1 and 2 and file them in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

BP

[Faint, mostly illegible handwritten text, possibly a ledger or account book. Some words like "Total" and "Balance" are faintly visible.]

49

**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO.

FOR
1- STATE
REGISTRAR

| | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|------------------|-----------------|---|--|--|--|--|----------------|--------------------------------|--|--|--|---|--|--|--|------|--|-------------------|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST
Samuel | | | MIDDLE
E. | | | LAST
Kellam | | | 2a. DATE KNOWN OF DEATH | | <input checked="" type="checkbox"/> MONTH | | DAY | | YEAR | | 2b. HOUR | | | |
| 3. SEX
Male | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
11/ 19/ 34 | | 6. AGE (IN YEARS LAST BIRTHDAY)
52 YRS. | | IF UNDER 1 YR.
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | | 2c. DATE PRONOUNCED DEAD | | MONTH | | DAY | | YEAR | | 2d. HOUR
5:25P | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
VA North Hampton Co. | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
4975 Denmore Street | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Construction | | | | 12b. KIND OF BUSINESS OR INDUSTRY
Talleys Con. | | | | | | | | | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | | 13b. COUNTY
Baltimore | | | | 13c. CITY OR TOWN
Baltimore | | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | 13e. STREET ADDRESS
4975 Denmore Ave. #15 | | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Frank Sterling | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Geneva Kellam | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
NO | | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
224-26-8970 | | | | 17. INFORMANT
Dorthy Kellam 4975 Denmore Ave. #15 | | | | | | | | | | | | | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Arteriosclerotic cardiovascular disease

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.

(b) DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

MEDICAL CERTIFICATION

| | | | | | |
|---|--|---|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |

22a. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL
SIGNATURE

TITLE (SPECIFY)
M.D. Assistant

MEDICAL EXAMINER

DATE SIGNED 12/23/86

EXAMINER'S NAME
(TYPE OR PRINT)

Gregory R. Kauffman, M.D.

ADDRESS

111 Penn St. Balto. MD.

| | | | | | | | |
|---|--|-----------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
12-29-86 | | 23c. NAME OF CEMETERY OR CREMATORY
King Memorial | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore County, Md. | |
| 24. FUNERAL DIRECTOR
NAME
William March Funeral Home 4300 Wabash Ave. | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 30 1986 | | 25b. REGISTRAR'S SIGNATURE
D. Davidson-Randall | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 6 3 4 0 0 4

| | | | | | |
|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Isabel A Keller | | | 2a. DATE OF DEATH
MONTH 12 DAY 26 YEAR 86 | | 2b. HOUR
12:01 AM |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH 7 DAY 10 YEAR 05 | | 6. AGE (IN YEARS LAST BIRTHDAY)
81 YRS. | IF UNDER 1 YEAR
MONTHS 1 DAYS 1 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
University of Maryland | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
housewife | 12b. KIND OF BUSINESS OR INDUSTRY
Homemaking | |
| 13a. STATE
Maryland | | | 13b. COUNTY
Baltimore | 13c. CITY OR TOWN
Kingsville | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME
FIRST Edward MIDDLE Holden LAST Holden | | | 15. MOTHER'S MAIDEN NAME
FIRST Lillian MIDDLE Richmond LAST Richmond | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Unknown | | 16b. SOCIAL SECURITY NO.
A705-05-4114 | | 17. INFORMANT
Charles Keller, son ADDRESS
P.O. Box 141 Kingsville, Md. 21087 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiorespiratory arrest
DUE TO, OR AS A CONSEQUENCE OF myocardial infarction
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) probable
(c) error | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
minutes |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (b) | | | | | |
| 19a. DATE OF OPERATION
none | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
none | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from December 25, 1986 , to December 26, 1986 , that (I) (we) last saw the deceased alive on December 26, 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Howard Clark Federer
DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED
12/26/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Howard Clark Federer | | | | 22e. ADDRESS
MIEMSS, University of Maryland Hospital. | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
12-29-86 | | 23c. NAME OF CEMETERY OR CREMATORY
Parkwood Cemetery | |
| 23d. LOCATION
CITY OR TOWN
Baltimore, Maryland | | STATE | | | |
| 24. FUNERAL DIRECTOR
NAME
E.F. Lissahn Funeral Home | | 24b. ADDRESS
11750 Belair Rd. BALTO. MD. 21087 | | 25. DATE REC'D. BY REGISTRAR
DEC 30 1986 | |
| 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that any death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

Date

Page No.



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3
27943 DEC 23 86STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH
REG. NO. 8634005

| | | | | | |
|--|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
RUBY M KELLY | | | 2a. DATE OF DEATH
MONTH DAY YEAR
NOVEMBER 29, 1986 | | 2b. HOUR
A
11:25 M |
| 3. SEX
Female | 4. RACE
Black | 5. DATE OF BIRTH
MONTH DAY YEAR
12/9/1961 | | 6. AGE (IN YEARS LAST BIRTHDAY)
24 YRS | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
- - - - |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
U.S. Virgin Is. | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE JOHNS HOPKINS HOSPITAL | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Veterinary Asst. | 12b. KIND OF BUSINESS OR INDUSTRY
Animal Sci. |
| 13a. STATE
Maryland | | 13b. CITY OR TOWN
A.A. Co. | 13c. CITY OR TOWN
Odenton | 13d. STREET ADDRESS / ZIP CODE
1309 Beltram Court, 21113 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Isidro Gomez | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Reubina Brown | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
N/A | | 17. INFORMANT
ADDRESS
Blair Kelly, 1309 Beltram Court, 21113 | |

| | | |
|---|---|--|
| MEDICAL CERTIFICATION | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i>
DUE TO, OR AS A CONSEQUENCE OF
(b) <i>Respiratory Arrest</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i>Chronic Active Hepatitis, Hepatic cirrhosis 8 years</i>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>2 weeks</i>
<i>8 minutes</i> | |
| | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<i>Infected left leg ulcer</i> | |
| | 19a. DATE OF OPERATION
<i>11/7/86</i> | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
<i>Left leg ulcer</i> |
| | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK
NOT WHILE <input type="checkbox"/> AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>10/25</i> 19 <i>86</i> , to <i>11/29</i> 19 <i>86</i> , that (I) (we) last saw the deceased alive on <i>11/29</i> 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | |
| 22b. SIGNATURE
<i>C. Lowell</i> | | 22c. DATE SIGNED
<i>11/29/86</i> |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>C. Lowell</i> | | 22e. ADDRESS
<i>601 N. Broadway, Belts, MD 21705</i> |

| | | | |
|--|----------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | 23b. DATE
12/2/86 | 23c. NAME OF CEMETERY OR CREMATORY
Westview Memorial Pk | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Catonsville, Baltimore Co, Md |
| 24. FUNERAL DIRECTOR
(NAME)
THE JAMES N. KORSIS FUNERAL HOME, 6411 Windsor | | 25a. DATE REC'D. BY REGISTRAR
DEC 4 1986 | |
| | | 25b. REGISTRAR'S SIGNATURE
<i>A. J. Jendryk-Randall</i> | |



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THE UNIVERSITY OF CHICAGO

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Klein, D.

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1309 BELLEVUE COURT, SALT LAKE CITY, UTAH

Journal of the American Medical Association

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CELLS, +WOOD MORTIMER ROSE, YOUNG WIFE EF 50-50-004

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12/15/50 New York Herald Tribune 12/15/50

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 34000

REG. NO.

| | | | | | |
|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Ruth E. Kelly | | 2a. DATE OF DEATH
MONTH 12 DAY 13 YEAR 86 | | 2b. HOUR
7:05 P.m. | |
| 3 SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH Oct. DAY 29 YEAR 1898 | |
| 6. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Balto., Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8. AGE (IN YEARS LAST BIRTHDAY)
88
YRS. MONTHS DAYS HOURS MIN. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
Jenkins Memorial Home | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD. | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife - Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
Md. | | 13b. COUNTY
Baltimore | | 13c. STREET ADDRESS / ZIP CODE
527 Nottingham Road-21229. | |
| 14. FATHER'S NAME
FIRST William MIDDLE J. LAST Costello | | 15. MOTHER'S MAIDEN NAME
FIRST Agnes MIDDLE ---- LAST Mc Cauley | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
216-48-2261 | | 17. INFORMANT Glen Burnette, 21061, Md.
Rev. John L. Kelly-1451 Furnace Av. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarction - CVD
DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial Infarction - FSL
DUE TO, OR AS A CONSEQUENCE OF (c) Myocardial Infarction - FSL
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12-15-86 19 to 12-15-86 19, that (I) (we) last saw the deceased alive on 12-15-86 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
George D. Dargatzis | | DEGREE
MD | | 22c. DATE SIGNED
12-15-86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
George D. Dargatzis | | 22e. ADDRESS
3350 Wilkes Dr. - Ky | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
12/16/86 | | 23c. NAME OF CEMETERY OR CREMATORY
St. John's Church Cem. - Hudes, Maryland | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE | | 24. FUNERAL DIRECTOR
NAME Sterling Funeral Estate, P.A. ADDRESS 736 Edmondson Ave., Catonsville, Md. 21228. | | | |
| 25a. DATE RECD. BY REGISTRAR
DEC 18 1986 | | 25b. REGISTRAR'S SIGNATURE
Julia Anderson-Rindley | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in by the funeral director, page 3 should be detached for use on the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

Handwritten notes and stamps, including a circular stamp in the center. The text is mostly illegible due to fading and bleed-through.

| | | | | | | | | | | | | | |
|---|--|-------------------------|--|--|--|---|--|---|--|---|--|---|--|
| FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
Rosella Kemp | | | | | | | | | | 2a. DATE KNOWN OF DEATH
MONTH DAY YEAR
12 15 19 86 | | 2b. HOUR
M
5:37 PM | |
| 3. SEX
Female | | 4. RACE
Col/2 | | 5. DATE OF BIRTH
MONTH DAY YEAR
11-15-22 | | 6. AGE (IN YEARS)
LAST BIRTHDAY
64 YRS. | | IF UNDER 1 YR.
MONTHS DAYS
0 0 | | 7c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
12 15 19 86 | | 2d. HOUR
M
5:37 PM | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
S.C. | | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Maryland General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 12. RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
STATE COUNTY
Maryland Baltimore | | | | 13c. CITY OR TOWN
Balto. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
2002 PArduesT Lancaster St | | | | 929938 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Andrew D. Harris | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Jean Simms | | | | 21217 | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
NO | | | | 16b. SOCIAL SECURITY NO.
225-46-4835 | | | | 17. INFORMANT
ADDRESS
Mr. Andrew Harris 819 Beon Clome | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic hypertensive cardiovascular disease
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | |
| ACTUAL SIGNATURE William M. Zane | | | | TITLE (SPECIFY)
M.D. Assistant MEDICAL EXAMINER | | | | DATE SIGNED 12/16/86 | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) William M. Zane, M.D. | | | | ADDRESS 111 Penn St. Balto.MD. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | 23b. DATE
12-21-86 | | 23c. NAME OF CEMETERY OR CREMATORY
New Hope Bapt Chm. | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Lancaster Co. S.C. | | | |
| 24. FUNERAL DIRECTOR
NAME
Joseph T. Russ | | | | ADDRESS
2222 W. North Ave. | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 19 1986 | | 25b. REGISTRAR'S SIGNATURE
John... | | | |

999999
97/84
BP

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS OF DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MD. 21201



1914-1915

029115 JAN 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0 3 4 0 0 8

REG. NO.

| | | | | | | | | | |
|---|--|---|---|--|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
CATHERINE M KEMPER | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 31 86 | | | 2b. HOUR
10:37 A.M. | | | |
| 3. SEX
Female | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH
MONTH DAY YEAR
02 19 94 | | 6. AGE (IN YEARS LAST BIRTHDAY)
92 YRS | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | | 9. CITIZEN OF WHAT COUNTRY?
USA | | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Balto. City MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMAR | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SOUTH BALTOGEN HOSP Balto. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
MD | | | | 13b. COUNTY
GLENDALE | | 13c. CITY OR TOWN
BALT | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
ANSELM ----- EHANT | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
SOPHIA ----- RICE | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
N/A | | 16b. SOCIAL SECURITY NO.
215-26-3817 | | 17. INFORMANT
ADDRESS
Francis Kemper 311 Hammons Lane Balto. Md. 21225 | | | | | |

| | | | |
|---|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
1/2 hr | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | (b) ASPIRATION PNEUMONITIS | |
| | | (c) DUE TO, OR AS A CONSEQUENCE OF | |
| | | one day | |

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

CONGESTIVE HEART FAILURE chx of Pneumonia

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/17/86, 19, to 12/31/86, 19, that (I) (we) last saw the deceased alive on 12/31/86, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Mansury D. Buck MD | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
12/31/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MANSURY D. BUCK | | | | 22e. ADDRESS
3001 South Hanover St. Baltimore, MD 21230 | | | |

| | | | | | | | |
|---|--|-----------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
1/3/1987 | | 23c. NAME OF CEMETERY OR CREMATORY
Holy Cross Cemt. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto. A. A. Co. Md. | |
| 24. FUNERAL DIRECTOR
NAME Balto. Md. 21230 ADDRESS
McCully Funeral Home, 130 E. Fort Ave. | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 2 1987 | | 25b. REGISTRAR'S SIGNATURE
Julia Sanderson | |

BP
DHMH - 16 60M 7/84
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The certificate must be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

20% COTTON FIBER

HEAVY DUTY

UNION BOND



027142 DEC 15 1986

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

34009

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) RUSSELL G. KENNEY | | | 2a. DATE OF DEATH
MONTH 12 DAY 6 YEAR 86 | | | 2b. HOUR
1:15 P.M. | |
| 3. SEX
M | | 4. RACE
B | | 5. DATE OF BIRTH
MONTH 3 DAY 15 YEAR 07 | | 6. AGE (IN YEARS LAST BIRTHDAY)
79 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARIAN MD | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
St Agnes Hosp | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING YEARS)
LABORER | |
| 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | |
| 13a. STATE
MD | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS
2119 W Mulberry St | | | | | | | |
| 14. FATHER'S NAME
FIRST John MIDDLE Kenney LAST Kenney | | | | 15. MOTHER'S MAIDEN NAME
FIRST Mary MIDDLE Dennis LAST 21223 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
215-05-0091 | | 17. INFORMANT
ADDRESS
MARY KENNEY 515 LOUDON AVE | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | |
| IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | |
| b) THROMBUS, LEFT CORONARY ARTERY | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| c) | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | |
| | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____. that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Michael E. Pelczar | | | | DEGREE
MD | | 22c. DATE SIGNED
12/6/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MICHAEL E. PELCZAR M.D. | | | | 22e. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
12.13.86 | | 23c. NAME OF CEMETERY OR CREMATORY
MT Zion | | 23d. LOCATION
CITY OR TOWN Baltimore COUNTY MD STATE | |
| 24. FUNERAL DIRECTOR
NAME William B. Hughes ADDRESS 635 N 9th St W 89 | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |

MEDICAL CERTIFICATION

19

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH-16 50M 1/81
(VRA 15, 4)

DEC 12 1986

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the death certificate from the papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



026459 DEC 9 1986

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Frances Kern | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 04 86 | | 2b. HOUR
8:15 A.M. |
| 3. SEX
Female | 4. RACE
white | 5. DATE OF BIRTH
MONTH DAY YEAR
12 15 02 | 6. AGE (IN YEARS LAST BIRTHDAY)
83 YRS | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
USA | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
City MD. | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
FSK MC | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | 12b. KIND OF BUSINESS OR INDUSTRY
Own Home | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE 13b. COUNTY
Maryland Baltimore | | | 13c. CITY OR TOWN
Dundalk | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
2713 W. Woodwell 21222 |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
George C Miller | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Frances Schieve | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | 16b. SOCIAL SECURITY NO.
218-18-2678 | | 17. INFORMANT ADDRESS
Barbara A. Sapak 625 W. Kingsway Rd. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>cardiac arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>myocardial infarct</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a
<u>respiratory distress</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 2</u> , 19 <u>86</u> , to <u>Dec 4</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>Dec 4</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>B. Fleming</u> | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
<u>12/4/86</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>B. Fleming</u> | | 22e. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
12-8-86 | 23c. NAME OF CEMETERY OR CREMATORY
Oak Lawn | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Maryland | | |
| 24. FUNERAL DIRECTOR
NAME
Duda-Ruck Funeral Home of Dundalk
7922 Wise Ave. Dundalk, MD 21222 | | 25a. DATE REC'D. BY REGISTRAR
DEC 8 1986 | | 25b. REGISTRAR'S SIGNATURE
<u>Julia Sinden-Randall</u> | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP _____
DHMH - 16 60M 7/B4
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the medical certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove the permit papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | |
|--|--|---|---|---|
| 1. DECEASED NAME
(Type or Print) Courtney Killen | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 29 86 | | 2b. HOUR
6 30 M |
| 3. SEX
female | 4. RACE
white | 5. DATE OF BIRTH
MONTH DAY YEAR
6 29 86 | 6. AGE (IN YEARS LAST BIRTHDAY)
6 mo YRS. | IF UNDER 1 YEAR
MONTHS DAYS
6 - |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
University of Maryland | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Maryland | | 13b. COUNTY
Howe | 13c. CITY OR TOWN
Ellicott City | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Kenneth Killen | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Carolyn Foley | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT
ADDRESS
Father 9962 Oaklea Ct Ellicott City 21043 |

| | | |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) pneumonia
DUE TO, OR AS A CONSEQUENCE OF
(b) Werdnig Hoffman Disease
DUE TO, OR AS A CONSEQUENCE OF
(c) | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
|--|--|---|

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

| | | | |
|---|--|--|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/28 , 19 86 , to 12/29 , 19 86 , that (I) (we) lost
saw the deceased alive on 12/29 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
Sharon Switzman | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
12/29/86 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Sharon Switzman | 22e. ADDRESS
22 S. Greene St Baltimore MD. | | |

| | | | |
|--|------------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
12-31-86 | 23c. NAME OF CEMETERY OR CREMATORY
New Cathedral | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto Md. |
| 24. FUNERAL DIRECTOR
NAME
Harry H. Witzke Family Funeral Home | | 25a. DATE REC'D. BY REGISTRAR
DEC 30 1986 | 25b. REGISTRAR'S SIGNATURE
Greta Gordon |
| 4112 Columbia Pike, Ellicott City, Md. | | | |

Delemona City

Delemona City

Delemona City



028896

JHL FOR 87

STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

34612

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|------------------|--|--|---|--|--|--|--|--|---|--|--|--------------------------------|--|--|--|--|--|--------------------------|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST
GEORGE | | | MIDDLE
P. | | | LAST
KING | | | 2a. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR | | | 2b. HOUR
M | | | | | | | | | | | | | | |
| 3. SEX
Male | | | 4. RACE
Black | | | 5. DATE OF BIRTH
MONTH DAY YEAR
1 19 13 | | | 6. AGE (IN YEARS LAST BIRTHDAY)
73 YRS. | | | IF UNDER 1 YR.
MONTHS DAYS | | | IF UNDER 24 HRS.
HOURS MIN. | | | 7c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
12 25 1986 | | | 7d. HOUR
P M
12:47 | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Va. | | | | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
501 Dolphin St. | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Disabled | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | |
| 13a. STATE
Md. | | | | | | 13b. COUNTY | | | | | | 13c. CITY OR TOWN
Balto. | | | | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | 13e. STREET ADDRESS
501 Dolphin St. Apt. 712 | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John C. King | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Eliza Jackson | | | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
Yes Yes | | | | | | 16b. SOCIAL SECURITY NO.
224-05-8950 | | | | | | 17. INFORMANT
ADDRESS
Jessie Wilson 2517 Salerno St. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
<i>Charles P. Kokes</i> | | | | | | TITLE (SPECIFY)
M.D. Assistant | | | | | | DATE SIGNED
12-29-86 | | | | | | | | | | | | | | | | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Charles P. Kokes, M.D. | | | | | | ADDRESS
111 Penn St., Balto., MD 21201 | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | | | | 23b. DATE
12/30/86 | | | | | | 23c. NAME OF CEMETERY OR CREMATORY
Garrison Forest Vet Cem | | | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Owings Mills, Md. | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Wm C March F/H West | | | | | | ADDRESS
4300 Wabash Ave. | | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 30 1986 | | | | | | 25b. REGISTRAR'S SIGNATURE
<i>Julia Davidson-Randall</i> | | | | | | | | | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))



—

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGE 1 AND 2 TO THE FUNERAL DIRECTOR. RETAIN PAGE 3 AND 4. RETAIN PAGE 5 FOR YOUR FILES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF RECORDS, 201 W. PRINCE STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|---------|--|---|--|-------------------|--|--|--|------------------|--|---|--|-------|--|---------------------------------------|--|------|--|----------|--|-----------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH | | MONTH | | DAY | | YEAR | | 2b. HOUR | | | | | | | |
| Helen | | | | | | King | | XX | | 12 | | 28 | | 1986 | | | | | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | MONTH | | DAY | | YEAR | | 2d. HOUR | | | |
| F | | W | | 04 DAY 01 MONTH 1900 YEAR | | 86 YRS. | | MONTHS | | DAYS | | HOURS | | MIN. | | 12 | | 30 | | 1986 | | 1:00 P.M. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | |
| MD | | | | USA | | | | | | | | Baltimore City, MD | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | |
| Baltimore | | | | 918 N. Durham Avenue | | | | HOUSEWIFE | | | | HOME | | | | | | | | | | | |
| 13a. STATE | | | | 13b. COUNTY | | | | 13c. CITY OR TOWN | | | | 13d. INSIDE CITY LIMITS? | | | | 13e. STREET ADDRESS | | | | | | | |
| MD | | | | | | | | BALTO | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 918 N. DURHAM AVE 21205 | | | | | | | |
| 14. FATHER'S NAME | | | | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | |
| FIRST MIDDLE LAST | | | | | | | | FIRST MIDDLE LAST | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | | | | | | 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT ADDRESS | | | | | | | | | | | |
| NO | | | | | | | | n/a | | | | 215106998 | | | | MICHAEL KING 226 S. BOULDIN ST. 21224 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | | | | | | | | | | |
| PART 1 DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | | | | | | | | | | | | | | |
| (b) _____ | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | |
| (c) _____ | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | | | | | | | | | | | | | | |
| 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | | | | | | | | | | | | | | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. I certify that I took charge of the remains described above, held on death resulted from <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | | | | | | | | | | | | | |
| 22c. I certify that I took charge of the remains described above, held on death resulted from <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | | | | | | | | | | | | | |
| 22d. I certify that I took charge of the remains described above, held on death resulted from <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | | | | | | | | | | | | | |
| 22e. I certify that I took charge of the remains described above, held on death resulted from <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | | | | | | | | | | | | | |
| 22f. I certify that I took charge of the remains described above, held on death resulted from <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | | | | | | | | | | | | | |
| 22g. I certify that I took charge of the remains described above, held on death resulted from <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | | | | | | | | | | | | | |
| 22h. I certify that I took charge of the remains described above, held on death resulted from <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | | | | | | | | | | | | | |
| 22i. I certify that I took charge of the remains described above, held on death resulted from <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | | | | | | | | | | | | | |
| 22j. I certify that I took charge of the remains described above, held on death resulted from <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | | | | | | | | | | | | | |
| 22k. I certify that I took charge of the remains described above, held on death resulted from <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | | | | | | | | | | | | | |
| 22l. I certify that I took charge of the remains described above, held on death resulted from <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | | | | | | | | | | | | | |
| 22m. I certify that I took charge of the remains described above, held on death resulted from <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | | | | | | | | | | | | | |
| 22n. I certify that I took charge of the remains described above, held on death resulted from <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | | | | | | | | | | | | | |
| 22o. I certify that I took charge of the remains described above, held on death resulted from <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | | | | | | | | | | | | | |
| 22p. I certify that I took charge of the remains described above, held on death resulted from <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | | | | | | | | | | | | | |
| 22q. I certify that I took charge of the remains described above, held on death resulted from <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | | | | | | | | | | | | | |
| 22r. I certify that I took charge of the remains described above, held on death resulted from <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | | | | | | | | | | | | | |
| 22s. I certify that I took charge of the remains described above, held on death resulted from <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | | | | | | | | | | | | | |
| 22t. I certify that I took charge of the remains described above, held on death resulted from <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | | | | | | | | | | | | | |
| 22u. I certify that I took charge of the remains described above, held on death resulted from <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | | | | | | | | | | | | | |
| 22v. I certify that I took charge of the remains described above, held on death resulted from <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | | | | | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial transit permit. Their plates require certain apprais. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or either trauma to the event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1. STATE
REGISTRAR

| | | | | | | | | | | |
|---|--|--|--|---|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) OLLEN D. KING | | | 2a. DATE OF DEATH MONTH DAY YEAR
12 26 86 | | | 2b. HOUR
4:15 AM | | | | |
| 3. SEX
MALE | | 4. RACE
BLACK | | 5. DATE OF BIRTH
MONTH DAY YEAR
08 27 03 | | 6. AGE (IN YEARS LAST BIRTHDAY)
83 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
N.C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Balto. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Mercy Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
md | | | 13b. COUNTY
Balto | | 13c. CITY OR TOWN
Balto | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
APT. 326 1300 E. Lanvale St 21215 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Lucius King | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
U/K | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | | 16b. SOCIAL SECURITY NO.
246-10-9742B | | 17. INFORMANT
Alma King | | ADDRESS
1900 E Lafayette ave. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) RESPIRATORY FAILURE | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | (b) CHRONIC PULMONARY FAILURE WEEKS | | |
| | | | | | | | | (c) ADENOCARCINOMA WEEKS | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from DEC 22 , 19 86 , to DEC 26 , 19 86 , that (I) (we) lost saw the deceased alive on DEC 23 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22a. SIGNATURE
Jonathan Arons | | | DEGREE
MD | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
12/26/86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JONATHAN ARONS | | | 22e. ADDRESS
MERCY 301 ST PAUL ST. BALTIMORE MD 21202 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
12-31-86 | | 23c. NAME OF CEMETERY OR CREMATORY
Arbutus Cem | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto County | | | |
| 24. FUNERAL DIRECTOR
NAME
Wm. C March | | | | | | ADDRESS
7/H 1101 E North Ave. | | 25a. DATE REC'D. BY REGISTRAR
DEC 30 1986 | | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE
John Darden-Rudner | | | | |

MEDICAL CERTIFICATION

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DEC 30 1968

027618 DEC 19 85

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86 34615
REG. NO.

| | | | | | | | | | |
|---|--|--|---|--------------------------------------|-----------------------------------|-----------------|--|------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST MIDDLE LAST | | 2a. DATE OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | |
| Thelma, Pauline King | | | | 11/20/86 | | | | 10:20 A.M. | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | |
| Female | Col | 2 | | 50 | | MONTHS DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Md. | U.S.A. | | | Baltimore city | | | | MD. | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| Baltimore city | North Charles General | | HomeMAKER | | | | | | |

| | | | | | | | | | |
|--|--|--------------------------|--|---------------------|--|--|--|--------------------------------|--|
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE | |
| Nid | | | | Baltimore | | | | 1715 Barclay St 21202 | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | | | | | | |
| Harry | | Biddle | | Lehona | | Reed | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | |
| No | | 217-66-3753 | | Mrs Myrtle Robinson | | 2132 W. Fairmont Ave | | 21273 | |

| | | | |
|---|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (a) <u>cerebrovascular thrombosis</u> | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | |
| (b) | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | |
| (c) | | | |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |

22a. I certify that (I) (this hospital) attended the deceased from 11/17 19 86, to 11/20 19 86, that (we) last saw the deceased alive on 11/20 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | | | | |
|---------------------------------------|--|--------------------|--|------------------|--|
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | |
| MARCO B. GALICIA | | | | 11/20/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| MARCO B. GALICIA | | 2222 W. North Ave. | | | |

| | | | | | | | |
|---|--|--------------------|--|------------------------------------|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| Burial | | 11/24/86 | | Mt. Zion | | Baltimore Md. | |
| 24. FUNERAL DIRECTOR NAME | | 24b. ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Joseph L. Russ | | 2222 W. North Ave. | | DEC 26 1986 | | Arlene Gordon-Randall | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please forward the completed papers. Pages 4 and 5 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be submitted within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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(VRA 15, 4)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon 1 and 2 and fill within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or interment. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic death, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | | | | | | |
|--|--|---|--|---|--|--|--|--|--|--|--|-------------------------------------|--|-----------|--|
| 1. FOR
STATE
REGISTRAR | | 2a. DECEASED NAME
(TYPE OR PRINT) | | 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7b. DATE OF DEATH
MONTH DAY YEAR | | 7c. HOUR | |
| | | Boris KIPRO | | MALE | | W White | | 04 20 1891 | | 95 | | 12 19 86 | | 1145 P.M. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | |
| Russia | | U.S.A. | | | | Baltimore City, MD. | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | |
| Baltimore | | Good Samaritan Hospital | | Labor | | Steel Co. | | | | | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. STATE | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS / ZIP CODE | | | | | | | |
| Maryland | | Baltimore | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 24 N. Ellwood Avenue 21224 | | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | | | | | | | | | | | | |
| Simeone Kipro | | Anna Mironovich | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES) | | 17. INFORMANT
ADDRESS | | | | | | | | | | | |
| No | | 213-07-4285 | | Nadya Wallach 2205 Echodale Avenue 21214 | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Severe Aspiration pneumonia</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| 22a. I certify that (he) (this hospital) attended the deceased from <u>12/19</u> 19 <u>86</u> to <u>12/19</u> 19 <u>86</u> that (he) (we) last saw the deceased alive on <u>12/19</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Elias Ghandour</u> | | DEGREE | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED
12/19/86 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>ELIAS GHANDOUR</u> | | 22e. ADDRESS
<u>5601- LOCHRAVEN BLVD. BALTO-MD.</u> | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | | | | | | | |
| Burial | | 12/23/86 | | Holy Trinity Cemetery | | Elkridge, Maryland | | | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | |
| Dippel Funeral Homes, Inc.
7110 Belair Road Baltimore, Maryland 21206 | | 12/22/1986 | | | | <u>J. A. Dippel</u> | | | | | | | | | |

3038

100% COTTON, BLUE

100% COTTON, BLUE

| | | | | | |
|--|-------------------------------------|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
George W. Kipp Jr. | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 17 86 | | 2b. HOUR
0329 ^{AM} | |
| 3. SEX
male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
06 06 '24 | | 6. AGE (IN YEARS LAST BIRTHDAY)
62 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore City | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
University of Maryland | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Sales Clerk | |
| 13a. STATE
MD | | 13b. CITY
Baltimore | | 13c. STREET ADDRESS / ZIP CODE
836 Mildred Avenue 21222 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
George William Kipp, Sr. | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Leotta Schmeletze | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
unknown | | 16b. SOCIAL SECURITY NO.
WWII
216-18-3407 | | 17. INFORMANT
Rose M. Kipp | |
| | | | | ADDRESS
Same as 13c. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>cardiorespiratory failure (No CPR)</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>cerebrovascular accident in post-operative period -> 11 days</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>coronary artery disease</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a. | | | | | |
| 19a. DATE OF OPERATION
12/6/86 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Coronary artery disease | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/4, 1986, to 12/17, 1986, that (I) (we) last saw the deceased alive on 12/16, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Atul N. Jani | | DEGREE
MD | | 22c. DATE SIGNED
12/17/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ATUL N. JANI | | 22e. ADDRESS
22 South Greene Street, Balto, MD 21201 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
12-20-86 | | 23c. NAME OF CEMETERY OR CREMATORY
Holly Hill | |
| | | | | 23d. LOCATION
Baltimore Maryland STATE | |
| 24. FUNERAL DIRECTOR
NAME
Duda-Ruck Funeral Home of Dundalk | | 25a. DATE REC'D. BY REGISTRAR
DEC 18 1986 | | 25b. REGISTRAR'S SIGNATURE
Julia S. ... | |
| | | | | 25c. REGISTRAR'S SIGNATURE | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon copy of page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked, item 18 should show any injury, or other traumatic event, if medical examiner must be notified at once.

[Faint, illegible handwritten text covering the majority of the page]

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027958 DEC 23 1986

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove the body papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | |
|---|--|---|--|---|----------------------------|
| 1. DECEASED NAME
(TYPE OR PRINT)
aka FIRST Donald MIDDLE Larry LAST Kirkendall
DONNIE L. KIRKENDALL | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 17 86 | | 2b. HOUR
5:25 AM |
| 3. SEX
male | 4. RACE
white | 5. DATE OF BIRTH
MONTH DAY YEAR
11 07 40 | | 6. AGE (IN YEARS LAST BIRTHDAY)
46 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Kentucky | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
South Baltimore Gen Hosp. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Electrician | |
| 13a. STATE
MD | | 13b. COUNTY
A.A. | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William H. Kirkendall | | 15. MOTHER'S MAIDEN NAME
MIDDLE LAST
Mary W. Goins | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
Viet Nam 212-40-2016 | | 17. INFORMANT
ADDRESS
Charlotte Kirkendall Same as 13e | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) cardiovascular insufficiency
DUE TO, OR AS A CONSEQUENCE OF
(b) myocardial infarction
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/17 , 19 86 , to 12/17 , 19 86 , that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Harold Blumenthal, MD | | | | 22c. DATE SIGNED
12/17/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Harold Blumenthal MD | | | | 22e. ADDRESS
3001 S. Hanover St Baltimore MD | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
12/19/86 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cem. | |
| 23d. LOCATION
CITY OR TOWN
Baltimore | | COUNTY
A.A. | | STATE
MD | |
| 24. FUNERAL DIRECTOR
George J. Gonce 4001 Ritchie Hwy Balto Md | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 19 1986 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
John F. Smith | |

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 3 4 6 1 7

REG. NO.

| | | | | | | | | | | | | | | | |
|---|--|--|---|--|------|--|--|--|--------------------------------------|---|--|------------------|-------------------------------|-------|--|
| 1 DECEASED NAME
(TYPE OR PRINT) | | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH DAY YEAR | | | | 2b. HOUR | | | | | |
| ALLEN | | | WALTER | KIRTSCHER | JR | DECEMBER 11, 1986 | | | | 6:00 P M | | | | | |
| 3 SEX | | | 4 RACE | | | 5. DATE OF BIRTH
MONTH DAY YEAR | | | 6 AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN. | | |
| MALE | | | WHITE | | | OCTOBER 3, 1928 | | | 58 YRS. | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | | | | |
| MARYLAND | | | USA | | | | | | BALTIMORE CITY MD. | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | |
| BALTIMORE | | | THE JOHNS HOPKINS HOSPITAL | | | (RET) LETTER CARRIER | | | U.S. POSTAL SER. | | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | 13a. INSIDE CITY LIMITS? | | | 13b. STREET ADDRESS / ZIP CODE | | | | | | |
| 13a. STATE | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 1111 REVOLUTION STREET 21078 | | | | | | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | | | | | | | | |
| ALLEN WALTER KIRTSCHER, SR. | | | | | | MINNIE DEBELIUS | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | | | | | 16b. SOCIAL SECURITY NO. | | | 17 INFORMANT ADDRESS | | | | | | |
| NO | | | | | | 214 24 8067 | | | MRS. IRENE J. KIRTSCHER SAME AS #13e | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | |
| IMMEDIATE CAUSE (a) Brain death | | | | | | | | | | | 20 min. | | | | |
| DUE TO, OR AS A CONSEQUENCE OF
(b) Hydrocephalus | | | | | | | | | | | 4 weeks | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(c) Subarachnoid hemorrhage | | | | | | | | | | | 5 weeks | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 11 8 86 | | | | Cerebral Aneurysm | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| | | | | P.M. 19 | | | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION
STREET | | CITY OR TOWN | | COUNTY | | STATE | |
| | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11-6, 1986, to 12-11, 1986, that (I) (we) lost
saw the deceased alive on 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | DEGREE | | | | | | 22c. DATE SIGNED | | | |
| Chris C Lin | | | | | | | | | | | | 12-11-86 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | 22e. ADDRESS | | | | | | | | | |
| CHRIS C LIN | | | | | | Johns Hopkins Hospital | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | | | |
| BURIAL | | | | 15 DECEMBER 86 | | ANGEL HILL CEMETERY | | | | HAVRE DE GRACE, HARFORD CO., MD. | | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| MITCHELL FUNERAL HOME PA, HAVRE DE GRACE, MD. 21078 | | | | | | DEC 16 1986 | | Julia Davidson-Pulley | | | | | | | |

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|
| 1- FOR STATE REGISTRAR | | | | | | | | | |
| 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR | | | | | | | | | |
| 3. SEX F 4. RACE W 5. DATE OF BIRTH MONTH DAY YEAR Mar. 14, 1927 6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS 7b. HOUR 2:20 AM | | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. 7b. CITIZEN OF WHAT COUNTRY? USA 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD. | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Memorial Hospital 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerical 12b. KIND OF BUSINESS OR INDUSTRY Telephone Co. | | | | | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 13b. COUNTY Baltimore 13c. CITY OR TOWN Towson 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS / ZIP CODE 802 Mockingbird La. 21204 | | | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Harold Frederick Meeth 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marie Carrick | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No 16b. SOCIAL SECURITY NO. 218 32 5303 17. INFORMANT ADDRESS Mr. Paul S. Arthur Severna Park, Md. 21146 | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hepatic Coma
DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC BREAST CARCINOMA
DUE TO, OR AS A CONSEQUENCE OF (c)
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | |
| 19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Nov 28, 1986, to Dec 13, 1986, that (I) (we) last saw the deceased alive on Dec 13, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I/we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Scott Rifkin MD 22c. DATE SIGNED 12/13/86 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Scott Rifkin, M.D. 22e. ADDRESS Union Memorial Hospital | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 23b. DATE 12/16/86 23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem. 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md. | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME MITCHELL-WIEDEFELD HOME, INC. ADDRESS 6500 York Rd. 25a. DATE REC'D BY REGISTRAR DEC 15 1986 25b. REGISTRAR'S SIGNATURE Julia L. ... | | | | | | | | | |

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | |
|--|---|---|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
HELEN D. KLOCHKO | | | 2a. DATE OF DEATH MONTH DAY YEAR
DECEMBER 1, 1986 | | 2b. HOUR
12:15 |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
10-12-1920 | 6. AGE (IN YEARS LAST BIRTHDAY)
66 YRS | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | 8b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 9. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE JOHNS HOPKINS HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Semi-retired | 12b. KIND OF BUSINESS OR INDUSTRY
Clothing Co. | |
| 13a. STATE
Md. | 13b. COUNTY
Baltimore | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
1227 Glyndon Ave 21223 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Joseph Tuzslo | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Keiser | | 16. ADDRESS
Baltimore, Md. 21122 | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
217-09-7302 | 17. INFORMANT
Geraldine R Davis 1415 Woodland Pch. Rd. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiopulmonary arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) Metastatic Colon Carcinoma
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
10 yrs. |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:
multiple pathological bone fractures. | | | | | |
| 19a. DATE OF OPERATION
11/13/86 11/21/86 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
ORIF R thigh L humerus | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/12, 1986, to 12/1, 1986, that (I) (we) last saw the deceased alive on 12/1, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Samuel C Kline | DEGREE
MD | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED
11/1/86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Samuel C Kline | 22e. ADDRESS
JNH Dept of Surg. | | 22f. ADDRESS
600 N. WOLFE ST. BALTO. MD. 21205 | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | 23b. DATE
12-4-1986 | 23c. NAME OF CEMETERY OR CREMATORY
Lafayette Redeemer Cmn | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Md. | 23e. DATE REC'D. BY REGISTRAR
DEC 4 1986 | |
| 24. FUNERAL DIRECTOR
NAME
J. P. Cowan & Son, Inc. | | 24b. ADDRESS
901 Belvoir St | | 25. REGISTRAR'S SIGNATURE
John T. ... | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon plates. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|---|--|--|--|---|
| FOR
STATE
REGISTRAR | | 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST <i>Thomas</i> MIDDLE <i>Charles</i> LAST <i>KLINGELHOFER</i> | 2a. DATE OF DEATH | MONTH <i>12</i> DAY <i>09</i> YEAR <i>86</i> | 2b. HOUR
<i>4:55 P</i> |
| 3. SEX
<i>MALE</i> | 4. RACE
<i>WHITE</i> | 5. DATE OF BIRTH
MONTH <i>1</i> DAY <i>29</i> YEAR <i>59</i> | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>27</i> YRS. | IF UNDER 1 YEAR
MONTHS <i></i> DAYS <i></i> | IF UNDER 24 HRS.
HOURS <i></i> MIN. <i></i> | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>Maryland</i> | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Baltimore City</i> MD. | | | | |
| 10. CITY OR TOWN OF DEATH
<i>BALTIMORE</i> | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>ESK MC</i> | | 12a. USUAL OCCUPATION
(TYPE OR WORK FOR MOST OF WORKING LIFE)
<i>Manager</i> | 12b. KIND OF BUSINESS OR INDUSTRY
<i>Fast Food</i> | | | |
| 13a. STATE
<i>Maryland</i> | | 13b. CITY OR TOWN
<i>Baltimore</i> | 13c. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13. STREET ADDRESS / ZIP CODE
<i>505 South 45th. Street 21224</i> | | | |
| 14. FATHER'S NAME
FIRST <i>Paul</i> MIDDLE <i></i> LAST <i>Hudlak</i> | | 15. MOTHER'S MAIDEN NAME
FIRST <i>Elizabeth</i> MIDDLE <i></i> LAST <i>Caison</i> | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>No</i> | 16b. SOCIAL SECURITY NO.
<i>213-76-5560</i> | 17. INFORMANT ADDRESS
<i>Elizabeth Regulski 505 S. 45th. St. 21224</i> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Cardio-respiratory arrest</i>
DUE TO, OR AS A CONSEQUENCE OF:
(b) <i>ANOXIC ENCEPHALOPATHY</i>
DUE TO, OR AS A CONSEQUENCE OF:
(c) <i></i> | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:
<i>IDPM, CRF</i> | | | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<i></i> P.M. <i>19</i> | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>12/01</i> 19 <i>86</i> to <i>12/09</i> 19 <i>86</i> , that (I) (we) last saw the deceased alive on <i>12/09</i> 19 <i>86</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<i>WJCS</i> | DEGREE | 22c. DATE SIGNED
<i>12/09/86</i> | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>CHIN</i> | 22e. ADDRESS
<i>Franklin Scott Key Med Ctr</i> | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<i>Burial</i> | 23b. DATE
<i>12-12-86</i> | 23c. NAME OF CEMETERY OR CREMATORY
<i>Oak Lawn Cemetery</i> | 23d. LOCATION
CITY OR TOWN <i>Eastwood, Balto Co., Md.</i> COUNTY STATE | | | | |
| 24. FUNERAL DIRECTOR
NAME <i>Charles S. Zeiler & Son Inc.</i> ADDRESS <i>901 S. Conkling St.</i> | | 25a. DATE OF DEATH BY REGISTRAR
<i>DEC 12 1986</i> | | 25b. REGISTRAR'S SIGNATURE
<i>John Beaton-Rodgers</i> | | | |

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FOR
STATE
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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | |
|--|--|------------------|---|--|--------------------------------|---|---|--|--|---|--|-----------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST MIDDLE LAST
Joseph Mathew Kloster | | | 2a. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR
12 23 1986 | | | 2b. HOUR
M
8:30A | | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
7/16/1929 | | 6. AGE (IN YEARS
LAST BIRTHDAY)
57 YRS. | | 7. IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | | 7c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
12 23 1986 | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
4500 Blk. Virginia Avenue | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Ret. Capt./Balto. City F.D. | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Maryland | | | 13b. COUNTY
--- | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 13e. STREET ADDRESS
4004 Sixth St., 21225 | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Ignatius Kloster | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Barbara Mildenberger | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
216-24-0333 | | 17. INFORMANT ADDRESS
Marian A. Kloster Same as #13 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
8147 IMMEDIATE CAUSE (a). Multiple injuries
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
8:25 PM 12 23 1986 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
Pedestrian struck by auto | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
street | | 21f. LOCATION
CITY OR TOWN COUNTY STATE
4500 Blk. Virginia Ave., Balto. MD | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | TITLE (SPECIFY)
M.D. Assistant MEDICAL EXAMINER | | | | | | DATE SIGNED 12/23/86 | | | |
| EXAMINER'S NAME (TYPE OR PRINT)
Gregory R. Kauffman, M.D. | | | | ADDRESS
111 Penn St. Balto. MD. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | 23b. DATE
12/27/86 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto., A.A. Co., Md. | | | |
| 24. FUNERAL DIRECTOR NAME
McCully Funeral Homes Balto. Md. 21225 | | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 30 1986 | | 25b. REGISTRAR'S SIGNATURE
Asia Twicken-Randall | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IMMEDIATELY IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 100.3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

RECEIVED
JAN 1 1930

NOTICE

(10)

RECEIVED
JAN 1 1930

027171 DEC 15 86

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 34024

REG. NO.

FOR
STATE
REGISTRAR

| | | | | | | | | |
|--|---|---|--------|--|----------------------------------|---|----------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR | |
| JOHN C KNESS | | | | | December 11, 1986 | | 5:30 PM | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 1 HRS. HOURS MIN. |
| Male | White | Mar. 28, 1898 | | 88 YRS. | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | |
| Maryland | U.S.A. | | | BALTIMORE CITY MD. | | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| BALTIMORE | UNION MEMORIAL HOSPITAL | | | Barber | | Barbering | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| Maryland | | | | | | Baltimore | | 13e. STREET ADDRESS / ZIP CODE |
| | | | | | | 1902-A Ramblewood Rd. 21239 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | | | |
| Conrad Kness | | Appolinia Wagner | | No - 21239 | | | | |
| 16a. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | | |
| 216-03-2673 | | Alice A. Kness 1902-A Ramblewood Rd. 21239 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Compressive heart failure</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary artery disease</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary artery disease</u>
CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>2 weeks</u>
<u>X 5 years</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Cerebrovascular Accident</u> | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from saw the death occurring on above, (I) (we) (we) did not; saw the body after death. | | 22b. SIGNATURE | | 22c. DATE SIGNED | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | |
| Dec 11, 1986 | | Dr. Ben M. Strong B. Bell MD | | 12/11/86 | | 3501 ST. Paul ST. - Balt MD | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | |
| Burial | | 12/13/86 | | Oaklawn Cemetery | | Baltimore Co. Maryland | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS | | | | 25. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| William E. Johnson 8521 Loch Raven Bl. | | | | DEC 12 1986 | | Julia Davidson-Randall | | |

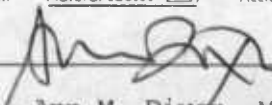

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | | | |
|---|---------|---|--|---|--|--|--|---|--------------------------------------|--------------------------|-----------------------------------|---|----------|--|
| FOR
1- STATE
REGISTRAR | | REG. NO. 3 4 0 2 5 | | | | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH | | | 2b. HOUR | | | |
| FANNIE | | | | KNIGHT | | | | DATE MATED <input checked="" type="checkbox"/> 12 25 19 86 | | | M 12:57 P | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD | | | 2d. HOUR | |
| F | B | 9 8 39 | | 47 YRS. | | | | | | 12 25 19 86 | | | 12:57 P | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| NC | | USA | | | | | | | Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Baltimore | | 1822 Aiken St. | | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | | |
| MD | | | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 1822 Aiken Street 21213 | | | | | | |
| 14. FATHER'S NAME | | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | |
| Ernest Jenkins | | | | | | Avelva Knight | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT | | | | ADDRESS | | |
| No | | | | 245-64-7654 | | | | Eva V. Preston | | | | 1806 Aiken Street | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Fatty metamorphosis of the liver</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? | | |
| | | | | | | | | | | | | Head & Abd. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | |
| | | | | P.M. 19 | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION | | | | | | |
| | | | | | | | | STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | TITLE (SPECIFY) | | | | DATE SIGNED | | | | | | |
|  | | | | M.D. Deputy Chief | | | | MEDICAL EXAMINER | | | | 12-26-86 | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS | | | | | | | | | | |
| Ann M. Dixon, M.D. | | | | 111 Penn St., Balto., MD | | | | 21201 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION | | | | | | |
| Burial | | 12/31/86 | | Pine Top Cemetery | | | | Pine Top NC | | | | | | |
| 24. FUNERAL DIRECTOR | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | |
| NAME ADDRESS | | | | DEC 30 1986 | | | |  | | | | | | |
| Wm. C. March Funeral Home West 1101 E. North Avenue | | | | | | | | | | | | | | |

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DEC 30 1988

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Item # 16b, Film G 623, 1/6/87 C

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | | | | | | |
|--|--|---|--|---|--|---|--|--|--|---|--|--|--|------|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRSE | | MIDDLE | | LAST | | 2a. DATE OF DEATH | | MONTH | | DAY | | YEAR | | 2b. HOUR | | | |
| WILLIAM DENNIS KNISLEY | | | | | | | | DECEMBER 23, 1986 | | | | | | | | 5:36P _M | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | | 7. IF UNDER 1 YEAR | | | | 8. IF UNDER 24 HRS. | | | |
| Male | | White | | March 13, 1915 | | | | 71 YRS. | | | | MONTHS | | | | DAYS | | | |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | | | | | | | | | |
| Virginia | | USA | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE JOHNS HOPKINS HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
A A Co. (Ret) | | | | 12b. KIND OF BUSINESS OR INDUSTRY
Dept. of Water | | | | | | | | | |
| 13. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | | | | | | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
A A Co. | | 13c. CITY OR TOWN
Severn | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
7733 Telegraph Road 21144 | | | | | | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
David Knisley | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Daisey (Unknown) | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WWII | | | | 17. INFORMANT (Daughter) ADDRESS
Mary A. Wood 17 Sweet Gum Road
Howell, New Jersey | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Recurrent Respiratory Arrests</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
<u>Coronary Artery Disease, Hypertension</u> | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>November 9</u> , 19 <u>86</u> , to <u>December 23</u> , 19 <u>86</u> , that (I) (we) lost
saw the deceased alive on <u>December 23</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Roger S. Blumenthal, MD</u> | | | | | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED
<u>12/23/86</u> | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>Roger S. Blumenthal, MD.</u> | | | | | | | | 22e. ADDRESS
<u>Tower 110; Johns Hopkins Hospital
Baltimore, MD 21205</u> | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | | 23b. DATE
Dec 27, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY
Savage Cemetery | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Savage Howard Md. | | | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Singleton Funeral Home | | | | | | | | ADDRESS
Glen Burnie, Maryland | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 30 1986 | | | | 25b. REGISTRAR'S SIGNATURE
<u>Julia Gordon-Padgett</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be received within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the Funeral Director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be placed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be contacted at once.

[Faint, illegible handwriting covering the page]

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|---|---|-----------------------------------|--|--|
| 1. DECEASED NAME
(Last, first, middle initial)
Edward John Kolb | | 2a. DATE OF DEATH
MONTH DAY YEAR
12/27/86 | | 2b. HOUR
MIN.
1:48 AM | |
| 3. SEX
Male | 4. RACE
Cauc | 5. DATE OF BIRTH
MONTH DAY YEAR
11/27/1913 | | 6. AGE (IN YEARS LAST BIRTHDAY)
73 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Mo. | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore city MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore city | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NONE IN SUCH FACILITY, GIVE STREET ADDRESS)
N. Charles Gen. Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
retired | |
| 13a. STATE
Mo. | | 13b. COUNTY
Balt. | 13c. CITY OR TOWN
Balt. | 13d. STREET ADDRESS / ZIP CODE
2914 Arundel Ave. 21216 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO.
272-143910 | | 17. INFORMANT
ADDRESS
2914 Arundel Ave. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Extensive pneumonia
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)
recent myocardial infarction; malnutrition | | | | | |
| 19a. DATE OF OPERATION
12/27/86 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 86 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/8 19 86 , to 12/27 19 86 , that I (we) last saw the deceased alive on 12/27 19 86 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Marcos B. Galicia Jr. MD | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
12/27/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MARCOS B. GALICIA, Jr. MD | | 22e. ADDRESS
North Charles General Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(CHECK IF)
Buried | | 23b. DATE
12/30/86 | | 23c. NAME OF CEMETERY OR CREMATORY
St. Hubert Cem. | |
| 23d. LOCATION
(CITY OR TOWN) COUNTY STATE
Baltimore city Baltimore Md. | | 23e. DATE REC'D. BY REGISTRAR
DEC 29 1986 | | | |
| 24. FUNERAL DIRECTOR
NAME
Erwin P. Carroll | | ADDRESS
1712-14 W. North Ave. | | 25b. REGISTRAR'S SIGNATURE | |

28632 DEC 31 1986

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8634629
REG. NO.

| | | | | | | | | | | |
|---|--|--|--|---|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
MARY ANNA KOLB | | | 2a. DATE OF DEATH
MONTH DAY YEAR
DECEMBER 26 1986 | | 2b. HOUR
4 P. M. | | | | | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
DEC. 5 1896 | | 6. AGE (IN YEARS LAST BIRTHDAY)
90 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
ELLERSLIE APTS.-601 Wyanoke Ave. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOMEMAKER | | 12b. KIND OF BUSINESS OR INDUSTRY
- | | |
| 13a. STATE
MD. | | | 13b. COUNTY
- | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
601 WYANOKE AVE. 21218 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
JOHN TROCH | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MARY UNKNOWN | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | | | |
| 16b. SOCIAL SECURITY NO.
217-01-2341 | | | 17. INFORMANT
ADDRESS
LOUIS KOLB (SON) 21907-107 Place, S.E. Kent., Wash. 98031 | | | | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Congestive Heart Failure</i>
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerotic C.V. Disease</i>
DUE TO, OR AS A CONSEQUENCE OF (c) <i>10 years</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
<i>Nutritional Anemia</i> | | | | | | | | | | |
| 19a. DATE OF OPERATION
- | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
- | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
- | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
- | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
- | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/6 , 19 86 , to 12/26 , 19 86 , that (I) (we) last saw the deceased alive on 12/6 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<i>Henry J. Houska MD</i> | | | DEGREE
MD | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12/29/86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Dr. Henry J. Houska | | | 22e. ADDRESS
333 S. East Ave. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
CREMATION | | | 23b. DATE
12/30/86 | | 23c. NAME OF CEMETERY OR CREMATORY
GREENMOUNT | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE MD. | | | |
| 24. FUNERAL DIRECTOR
NAME
SCHIMUNEK FUNERAL HOME, INC.
ADDRESS
3331 Brehms Lane, Balto. Md. 21213 | | | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
DEC 29 1986 <i>Julia Denham</i> | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

20% COTTON FIBER

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MIN

100

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027441 DEC 17 1986

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

86 34630

| | | | | | | | | | | | | |
|--|---------|---|-------------------|--|------------------|---|-------------------------------|---|-----------------------------------|---|----------|--|
| FOR
1- STATE
REGISTRAR | | DECEASED NAME
(TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 7a. DATE KNOWN
OF
DEATH | | 7b. MONTH | 7c. DAY | 7d. YEAR | 7e. HOUR |
| | | GARY Charles KOKTA | | | | | 12-13-86 | | | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) | 7. UNDER 1 YR. | 8. UNDER 24 HRS. | 9. DATE | 10. MONTH | 11. DAY | 12. YEAR | 13. HOUR | | |
| Male | White | Oct. 7, 1965 | 21 YRS. | | | 12-13-86 | | | | | 5:12 AM | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | |
| Md. | | USA | | | | Baltimore City | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Baltimore | | University Hospital STU | | | | Construction | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | |
| Md. | | | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 3328 Bayonne Ave. 21214 | | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | |
| Kenneth J. Kokta Sr. | | | | Doris L. Click | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | | |
| no | | | | 220-88-5183 | | Mr. Kenneth J Kokta Sr. Same | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Multiple injuries | | | | | | | | | | | | |
| 8/22 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. | | | | | | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | |
| (c) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 1a. | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? | | |
| | | | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | |
| | | | | 4:40 PM 12-12-86 | | | | driver of a motorcycle in collision with another vehicle | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION | | | | |
| | | | | street | | | | Harford Rd. 3mi. No of Balto. Co., Md. Long Green Pike | | | | |
| 22a. I certify that I took charge of the remains described above, held as death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | TITLE (SPECIFY) | | | | DATE | | | SIGNED | |
| John E. Smialek, M.D. | | | | Chief | | | | 12-13-86 | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS | | | | | | | | |
| John E. Smialek, M.D. | | | | 111 Penn Street | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION | | | |
| Burial | | | | Dec. 17, 1986 | | Most Holy Redeemer | | | Baltimore Md. | | | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | |
| Leonard J. Ruck Inc. Baltimore, Maryland | | | | | | DEC 15 1986 | | | Julius Anderson-Randall | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER ALONG WITH FORM 1. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/B4
25M

BP
DHMH - 17
(VR A15 ME (5))

037 01 0175

Chicago
Date: Dec. 7, 1967

Investigation

7308 Lawrence Ave. #101

Chicago

Office

Chicago

12. 10. 1967

12. 10. 1967



Ill.

Edward J. Smith Inc. Chicago, Illinois

029376 JAN 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|--|---|---|--|---|---|--|
| FOR STATE REGISTRAR | | | | | REG. NO. | | | | |
| 1 DECEASED NAME (TYPE OR PRINT) | | | | | 2a DATE OF DEATH | | | | |
| FIRST MIDDLE LAST
Eva Kolker | | | | | MONTH DAY YEAR HOUR
12 27 06 1200 PM | | | | |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH | | 6 AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR IF UNDER 24 HRS | |
| Female | | WHITE | | MONTH DAY YEAR
12 13 1892 | | 94 YRS | | MONTHS DAYS HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Russia | | U.S. | | | | Baltimore city MD. | | | |
| 10 CITY OR TOWN OF DEATH | | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b KIND OF BUSINESS OR INDUSTRY | |
| BALTIMORE | | LEVINDALE GERIATRIC HOSPITAL | | | | MERCHANT | | RETAIL | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | 13b INSIDE CITY LIMITS? | | 13c STREET ADDRESS / ZIP CODE | | |
| STATE CITY OR TOWN
MARYLAND BALTO. BALTO. | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 1 WOODHUE CT. (21207) | | |
| 14 FATHER'S NAME | | | | | 15 MOTHER'S MAIDEN NAME | | | | |
| FIRST MIDDLE LAST
PHILLIP SILVERMAN | | | | | FIRST MIDDLE LAST
TEMA RESA UNKNOWN | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | | 16b SOCIAL SECURITY NO. | | 17 INFORMANT ADDRESS | | |
| NO | | | | | 212-52-9812 | | MRS. YETTA GRAVINER 1 WOODHUE CT. (21207) | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. | | | | | | | | | |
| IMMEDIATE CAUSE (a) MASSIVE CVA | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral ischemic vascular disease | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | |
| 19a DATE OF OPERATION | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY? | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.) | | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a I certify that (I) (this hospital) attended the deceased from 04/04 19 86, to 12-27 19 86, that (I) (we) lost saw the deceased alive on 12-27 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b SIGNATURE | | | | | DEGREE | | 22c DATE SIGNED | | |
| [Signature] | | | | | | | 12-27-86 | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | 22e ADDRESS | | | | |
| B. ZAW-LIN, MD | | | | | Levindale Geriatric Ctr BALTO 21215 | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION CITY OR TOWN COUNTY STATE | | |
| BURIAL | | | 12/29/86 | | ANSHE EMUNAH | | BALTO., BALTO., MD. | | |
| 24 FUNERAL DIRECTOR (NAME) | | | | | | 25a DATE REC'D. BY REGISTRAR | | 25b REGISTRAR'S SIGNATURE | |
| SOL LEVINSON & BROS. 6010 REISTERSTOWN RD. BALTO., MD. (21215) | | | | | | JAN 6 1987 | | Julia Davidson-Randall | |

100-100000



027473 DEC 17 1986

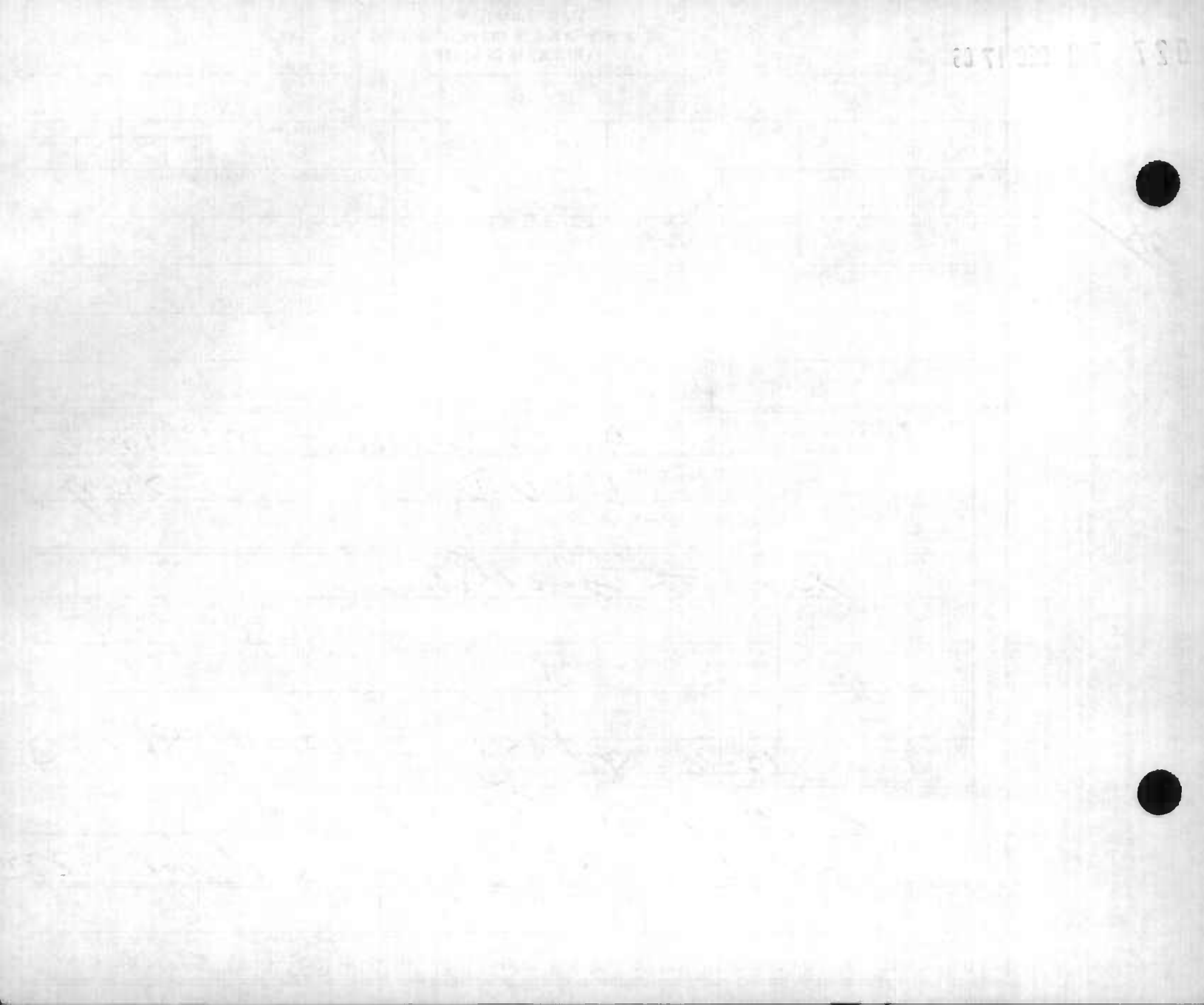
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with a 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 0 3 4 0 3 2 | | | |
|---|--|--|--|--|--|--|--|
| FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME
(TYPE OR PRINT)
John A. Kopicky | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12-15-86 | | 2b. HOUR
3:30 A.M. | |
| 3 SEX
MALE | | 4 RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
6-17-13 | | 6 AGE (IN YEARS LAST BIRTHDAY)
73 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Scranton, Pa. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10 CITY OR TOWN OF DEATH
Baltimore | | NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Francis Scott Key Medical Center | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Wood Working Dept. | | 12b. KIND OF BUSINESS OR INDUSTRY
Correctional | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md. | | | | 13b. CITY OR TOWN
Balto. City | | 13c. STREET ADDRESS / ZIP CODE
2104 Cameron Dr. Apt. 1B - 21222 | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
Matthew Kopicky | | | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Amelia H. Savage | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
212-03-7666 | | 17. INFORMANT ADDRESS
Elmer L. Kopicky - 9105 Lamaze Rd. - 21234 | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) As CVD-recent MI
DUE TO, OR AS A CONSEQUENCE OF (b) H CVD
DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes mellitus
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 year
20 yrs | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Diabetes mellitus | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
1982 12-14 1986 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
6730 Holabird Ave Baltimore, Md. | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12-16-86 and that (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did/did not) view the body after death. | | | | 22b. SIGNATURE
W.K. WONG M.D. | | 22c. DATE SIGNED
DEC 16 1986 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
W.K. WONG M.D. | | | | 22e. ADDRESS
6730 Holabird Ave Baltimore, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
12-18-86 | | 23c. NAME OF CEMETERY OR CREMATORY
Oak Lawn Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Md. | |
| 24 FUNERAL DIRECTOR
NAME ADDRESS
John C. Miller Inc.-6415 Belair Road-21206 | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 16 1986 | | 25b. REGISTRAR'S SIGNATURE
Lia Swenson-Randall | |



027447 DEC

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | |
|---|-----------------------------|--|---|--|--|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) John J Kovacs | | | 2a. DATE OF DEATH
MONTH 12 DAY 15 YEAR 86 | | | 2b. HOUR
10:00 AM | | |
| 3. SEX
M | 4. RACE
Caucasian | 5. DATE OF BIRTH
MONTH 4 DAY 7 YEAR 1910 | | 6. AGE (IN YEARS LAST BIRTHDAY)
76 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
South Baltimore General Hospital | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Trucker | | 12b. KIND OF BUSINESS OR INDUSTRY
Truck | |
| 13a. STATE
MD | | | | 13b. COUNTY
 | | 13c. CITY OR TOWN
Baltimore | | |
| 14. FATHER'S NAME
FIRST Antone MIDDLE LAST Kovacs | | 15. MOTHER'S MAIDEN NAME
FIRST UNKNOWN MIDDLE LAST | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Unknown | | 16b. SOCIAL SECURITY NO.
1140 33153 A | | 17. INFORMANT
ADDRESS
Hilda Kovacs 1435 Cooks St 91330 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory failure
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
 | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Hypertension, Dehydration, Iron overload Anemia, Hemochromatosis | | | | | | | | |
| 19a. DATE OF OPERATION
10/19 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
 | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
 | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
 | | 21f. LOCATION
STREET
 | | CITY OR TOWN
 | | STATE
 |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/19 , 19 86 , to 12/15 , 19 86 , that (I) (we) last saw the deceased alive on 12/15 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE
Song Chol Chon | | | | DEGREE
M.D. | | 22c. DATE SIGNED
12/15/86 | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Song Chol CHON | | | | 22e. ADDRESS
3001 S. Hanover St Baltimore, MD 21227 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(CHECK)
Burial | | 23b. DATE
12/18/86 | | 23c. NAME OF CEMETERY OR CREMATORY
Glen Haven Cem. | | 23d. LOCATION
CITY OR TOWN Glen Burnie Md. COUNTY STATE | | |
| 24. FUNERAL DIRECTOR
Stevens Funeral Home Inc. | | | | ADDRESS
1501 E. 1st Ave | | 25a. DATE REC'D. BY REGISTRAR
DEC 16 1986 | | 25b. REGISTRAR'S SIGNATURE
Julie Davidson |

MEDICAL CERTIFICATION

9

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

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028103 DEC 29 1986

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL, OF-ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon pages 1 and 2 and hold them until 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, a medical examiner must be called at once.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | |
|---|--|--|---|--|---|---|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | 2a. DATE OF DEATH | | | MONTH DAY YEAR | | | 2b. HOUR | | | |
| FIRST MILDRED I. LAST KRAFT | | | 12 21 86 | | | 10:45 P.M. | | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | |
| Female | | White | | 4 19 16 | | 70 YRS. | | | MONTHS DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | |
| MARYLAND | | US | | | | BALT. CITY MD. | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| BALT. | | SOUTH BALT. GEN. HOSP. | | | | RETIRED | | | Arnolds Pac. | | | |
| 13a. STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS / ZIP CODE | | | |
| MD. | | | BALT. | | BALT. | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | Balto Md
1735 CLARKSON ST., 21230 | | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | |
| FIRST MIDDLE LAST
GEORGE ---- SWEET | | | FIRST MIDDLE LAST
EDNA ---- GLAZER | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT ADDRESS | | | | | | |
| -UNK- No | | | 220033970 | | | CHART William Riegel, Same as above | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>BREAST & LUNG CANCER</u>
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | |
| | | | HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | | | | | | |
| 21d. INJURY OCCURRED | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | | | | | | | |
| WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | | CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/28</u> , 19 <u>86</u> , to <u>12/21</u> , 19 <u>86</u> that (I) (we) last saw the deceased alive on <u>12/21</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE | | | DEGREE | | | | 22c. DATE SIGNED | | | | | |
| <u>G. Weiss</u> , MD | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 12/21/86 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22e. ADDRESS | | | | | | | | | |
| GUSTAVE V. WEISS | | | 3001 S. HANOVER ST., BALT. MD. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | | | |
| Cremation | | | 12/22/86 | | Security Process, Inc. | | CITY OR TOWN COUNTY STATE
Catonsville, Balto. Co. | | | | | |
| 24. FUNERAL DIRECTOR | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| NAME Balto. Md. 21230 ADDRESS
McCully Funeral Home, 130 E. Fort Ave. | | | DEC 23 1986 | | | | Julia Sanders-Randall | | | | | |

MEDICAL CERTIFICATION

1990

1992

1999

0805.72 407.100 281.

742

1998

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1994

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028315 DEC 22 1986
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|---|--|---|-----------------------------|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
FRANCIS J. KREER | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 17 86 | | 2b. HOUR
12:39 AM | | | | |
| 3. SEX
Male | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
9 23 14 | | 6. AGE (IN YEARS LAST BIRTHDAY)
72 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Delaware | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
University of Maryland Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Cabinet Maker. | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | | | | 13b. COUNTY
Cecil | | 13c. CITY OR TOWN
Elkton | |
| 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
628 Leeds Rd., 21921 | | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Theodore Kreer | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Florence Johnson | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
214 10 6784 | | 17. INFORMANT
Harriet A. Kreer, 628 Leeds Rd., Elkton, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIAC ARREST | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
30 min | |
| DUE TO, OR AS A CONSEQUENCE OF
(b) GASTROINTESTINAL BLEEDING | | | | | | | | 17 days | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) GASTRIC ULCER | | | | | | | | 20 days | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: CARCINOMA of PROSTATE | | | | | | | | | |
| 19a. DATE OF OPERATION
11/27/86 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Emergency for bleed gastric Ulcus | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
22 S. Greene St. Balt MD 21201 | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/18 , 19 86 , to 12/17 , 19 86 that (I/we) last saw the deceased alive on 12/17/86 , 19 86 , and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did/did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Roderick P. Zickler | | DEGREE | | 22c. DATE SIGNED
12/17/86 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Roderick P. Zickler MD | | 22e. ADDRESS
22 S. Greene St. Balt MD 21201 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
12/20/86 | | 23c. NAME OF CEMETERY OR CREMATORY
Leeds Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Leeds Cecil Md. | | | |
| 24. FUNERAL DIRECTOR
Hicks Home for Funerals | | | | ADDRESS
Elkton, Md. | | 25a. DATE REC'D. BY REGISTRAR
DEC 22 1986 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then place your carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

THE UNIVERSITY OF CHICAGO
LIBRARY

03011 17320



027649 DEC 12 1986

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|---|--|---|--|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) LENA | | FIRST | | MIDDLE | | LAST KRUSZEWSKI | | 2a. DATE OF DEATH
MONTH DAY YEAR
12/11/86 | | 2b. HOUR
10 00 PM | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Jan. 30 1900 | | 6. AGE (IN YEARS LAST BIRTHDAY)
86 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Francis Scott Key | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
Md. | | 13b. COUNTY
Balto. | | 13c. CITY OR TOWN
White Marsh | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
11308 Bird River Grove Rd. 21162 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
George Ulrich | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Veronica Grynciwich | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO.
217-50-1098 | | 17. INFORMANT ADDRESS
Frances Dombrowski 7627 Philadelphia Rd. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) cardiac arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: hemoptysis | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on 12/11/86 , 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Patricia Hsia | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED
12/14/86 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
PATRICIA C Hsia | | 22e. ADDRESS
4940 Eastern Ave Baltimore MD 21224 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
12/15/86 | | 23c. NAME OF CEMETERY OR CREMATORY
Holly Hill Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Middle River Balto. Maryland | | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Connelly Funeral Home 300 Mace Ave. 21221 | | 25a. DATE REC'D. BY REGISTRAR
DEC 17 1986 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | | | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP _____



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028802 JAN

DIVISION OF VITAL RECORDS 201 W. PRESTON ST. BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | |
|---|---|---|-------------|---|--|---|--|--------------------------------|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST
MARY | MIDDLE
J | LAST
KURLYCHEK | 2a. DATE OF DEATH
MONTH DAY YEAR
DECEMBER 23, 1986 | | 2b. HOUR
1:35 P
M | |
| 3. SEX
female | 4. RACE
white | 5. DATE OF BIRTH
MONTH DAY YEAR
Jan. 6, 1954 | | 6. AGE (IN YEARS LAST BIRTHDAY)
7RS. 32 | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New Jersey | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE JOHNS HOPKINS HOSPITAL | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
researcher | | 12b. KIND OF BUSINESS OR INDUSTRY
self-emp. | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE 13b. CITY OR TOWN
Md. A.A. Co. Edgewater | | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
1651 Lee Dr. 21037 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Tom Vouglas | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Marion Demko | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
141-48-9912 | | 17. INFORMANT ADDRESS
Kenneth L. Kurlychek same as 13 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
35 minutes | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) HEPATIC FAILURE | | | | | | | 2 WEEKS | |
| (c) GRAFT VERSUS HOST DISEASE | | | | | | | 7 MONTHS | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: RENAL FAILURE | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from DECEMBER 4, 1986, to DECEMBER 23, 1986, that (I) (we) last saw the deceased alive on DECEMBER 23, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE
Jon R. Resar MD | | | | DEGREE
M.D. | | 22c. DATE SIGNED
12/23/86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JON R. RESAR M.D. | | | | 22e. ADDRESS
JOHNS HOPKINS HOSPITAL | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
12/27/86 | | 23c. NAME OF CEMETERY OR CREMATORY
Woodfield Cem | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Galesville A.A. Md. | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
HARDESTY FUNERAL HOME 12 RIDGELY AVE, ANN. | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 30 1986 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | |

BP

050000-1-11

1. 18 00 15 0
2. 18 00 15 0
3. 18 00 15 0
4. 18 00 15 0
5. 18 00 15 0
6. 18 00 15 0
7. 18 00 15 0
8. 18 00 15 0
9. 18 00 15 0
10. 18 00 15 0

1. 18 00 15 0

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3. 18 00 15 0

4. 18 00 15 0

5. 18 00 15 0

6. 18 00 15 0

7. 18 00 15 0

8. 18 00 15 0

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10. 18 00 15 0

11. 18 00 15 0

12. 18 00 15 0

13. 18 00 15 0

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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DHMH - 15, 50M 4/83
VRA 15, A

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|---|--|--|--|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
MARY Kusy | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 26 86 | | | 2b. HOUR
5⁰⁰ P.M. | | | | | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
11 26 18 | | 6. AGE (IN YEARS LAST BIRTHDAY)
68 YRS. | | 7. UNDER 1 YEAR
MONTHS DAYS
68 | | 8. UNDER 24 HRS.
HOURS MIN.
5⁰⁰ | |
| 7a. BIRTHPLACE (STATE OR FOREIGN)
POLAND | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore City | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Singi Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK OR MOST OF WORKING LIFE)
HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY
HOMEMAKER | | | |
| 13a. STATE
ILLINOIS | | 13b. COUNTY
COOK | | 13c. CITY OR TOWN
Chicago | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
6346 N. Kedzie 60659 | | | |
| 14. FATHER'S NAME
MENACHEM MIDDLE PODOLSKY LAST GIHANNA | | | 15. MOTHER'S MAIDEN NAME
GITTEL LAST | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
215-40-5136 | | 17. INFORMANT 6132 N. CALIFORNIA AVE. 60659
PISER- WEINSTEIN MEM. CHAPEL CHICAGO, ILL. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Cerebral Brain Death
DUE TO, OR AS A CONSEQUENCE OF
(b) Intracerebral hemorrhage
DUE TO, OR AS A CONSEQUENCE OF
(c) Hypertension
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a
Hypertension | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
1 day | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from December 25, 19 86 to December 26, 19 86 , that (I) (we) last saw the deceased alive on December 26, 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Robert K. Roby | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED
12/27/86 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Robert K. Roby | | | | 22e. ADDRESS
Singi Hospital | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
BURIAL / REMOVAL | | 23b. DATE
12/29/86 | | 23c. NAME OF CEMETERY OR CREMATORY
WESTLAWN CEM | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
CHICAGO, ILL | | | | | |
| 24. FUNERAL DIRECTOR
NAME SOL Levinson & BROS. ADDRESS BALTO., MD. (21215) | | | | BALTIMORE REC'D. BY REGISTRAR
JAN 6 1987 | | 25. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | | | | |

Page 3 may be retained by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. This permit must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | REG. NO. | |
|--|--|--|---|--|--|---|
| 1. DECEASED NAME
(Type or Print) Renato Leonard Lanciotti | | | 2a. DATE OF DEATH
MONTH DAY YEAR
December 30, 1986 | | 2b. HOUR
8¹⁵ P.M. | |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
Feb. 14 1902 | 6. AGE (IN YEARS LAST BIRTHDAY)
84 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Italy | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Mercy Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired Musician | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Maryland | | 13b. COUNTY
Baltimore | 13c. CITY OR TOWN
Reisterstown | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
117 Northway Rd. 21136 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Pasquale Lanciotti | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Fedeli DiAngelo | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
216-09-9636 | | 17. INFORMANT
ADDRESS
Vera A. Lanciotti Same as Above | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arterio sclerotic coronary vascular disease
DUE TO, OR AS A CONSEQUENCE OF
(b) congestive cardiomyopathy
DUE TO, OR AS A CONSEQUENCE OF
(c) refractory ventricular arrhythmia | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
years
years
days |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from December 29, 1986 , to December 30, 1986 , that (I) (we) last saw the deceased alive on December 30, 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
Helen Walker MD | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
12/30/86 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Helen Walker MD | | 22e. ADDRESS
Mercy Hospital
301 St Paul Place Baltimore | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
1-3-87 | | 23c. NAME OF CEMETERY OR CREMATORY
Lake View Mem. Park | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Sykesville Carroll Md. |
| 24. FUNERAL DIRECTOR
NAME
Eline Funeral Home ADDRESS
Reisterstown, Md. | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 31 1986 | | 25b. REGISTRAR'S SIGNATURE
Julia Twiss-Randall |

BP

167-111 00025

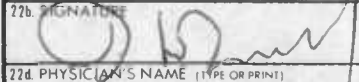
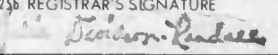
167-111

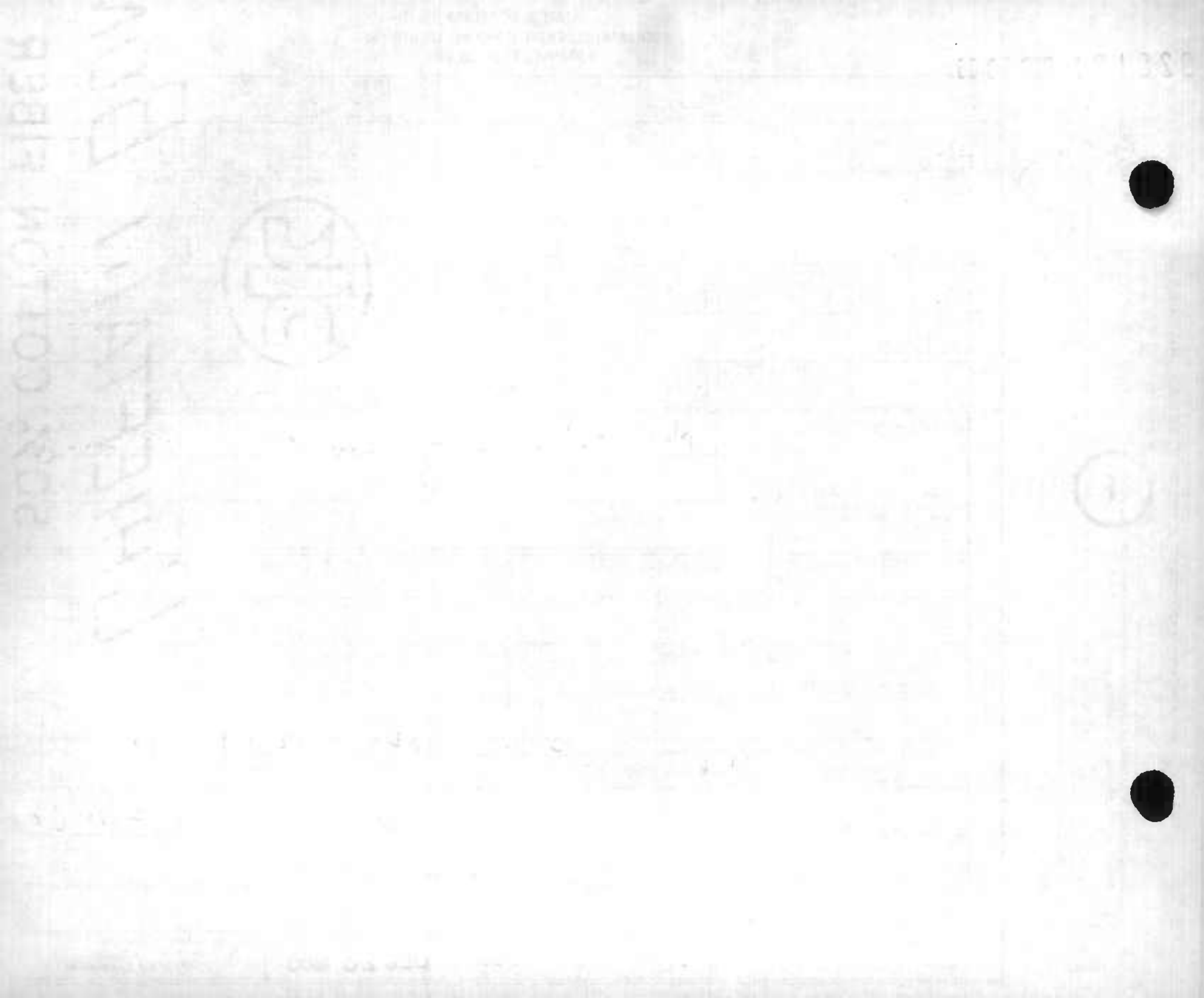
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Their planer remains on bon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called and consulted.

DHMH - 16 60M 7/84
(VRA 15, 4)

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | | | | | |
|--|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Antal Lajos | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12-18-86 | | | | 2b. HOUR
2 P. M | |
| 3. SEX
Male | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
4-2-1921 | | 6. AGE (IN YEARS LAST BIRTHDAY)
65 yrs. YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN)
Hungary | | 7b. CITIZEN OF WHAT COUNTRY?
Hungary | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Balto. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
3040 E. Monument Street | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Welding | | 12b. KIND OF BUSINESS OR INDUSTRY
Ackerman & | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md. | | | | 13b. COUNTY | | 13c. CITY OR TOWN
Balto. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Unknown | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE
Unknown | | | | 13e. STREET ADDRESS / ZIP CODE
3040 E. Monument Street 21205 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
141-32-8679 | | 17. INFORMANT
Lillian M. Lajos | | | | ADDRESS
same address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic Lung cancer | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
3 months | |
| DUE TO, OR AS A CONSEQUENCE OF
(b) _____ | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____ | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21i. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/16 , 19 82 , to 12/18 , 19 86 , that (I) (we) last saw the deceased alive on 12/18 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
 | | | | | | DEGREE | | 22c. DATE SIGNED
12/20/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Dr. Dennis McDonald | | | | | | 22e. ADDRESS
9 S. Highland Avenue | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
12-22-86 | | 23c. NAME OF CEMETERY OR CREMATORY
Oak Lawn Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto., Md. | | |
| 24. FUNERAL DIRECTOR
Schmunk Funeral Home, Inc.
3331 Brehms Lane, Balto., Md. 21213 | | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 23 1986 | | 25b. REGISTRAR'S SIGNATURE
 | |



28776 DEC 31 1986

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 3 4 6 4 1

REG. NO.

| | | | | | | | |
|---|--|--|---|---|---------------------------|--|--|
| 2. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
MARIE Stella LANAHAN | | | 2a. DATE OF DEATH
MONTH DAY YEAR
DECEMBER 26, 1986 | | 2b. HOUR
850P M | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
9-5-1920 | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS. MONTHS DAYS HOURS MIN.
66 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE JOHNS HOPKINS HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Ret. Drug Mgr., Pantry Pride | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Md. | | 13b. COUNTY
Balto. | | 13c. CITY OR TOWN
Balto. | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13e. STREET ADDRESS / ZIP CODE
8212 Harris Ave. 21234 | | 14. FATHER'S NAME
FIRST MIDDLE LAST
John Agro | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Florence Unknown | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | |
| 16b. SOCIAL SECURITY NO.
215-07-4285 | | 17. INFORMANT
Charles E. Lanahan, Same as 13e | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiopulmonary arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) hepatic failure
DUE TO, OR AS A CONSEQUENCE OF
(c) pancreatic carcinoma | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 minute
1 week
6 years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from 12/24 , 19 86 to 12/26 , 19 86 that (1) (we) lost saw the deceased alive on 12/26 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Elaine C. Helf, M.D. | | | | DEGREE
ATTENDING PHYSICIAN MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12/26/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Elaine Helf | | | | 22e. ADDRESS
600 N. Wolfe St. Baltimore, MD 21205 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
12-30-86 | | 23c. NAME OF CEMETERY OR CREMATORY
Dulaney Valley | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Cockeysville Md. | |
| 24. FUNERAL DIRECTOR
NAME
Leonard J. Ruck, Inc., 5305 Harford Rd. | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 29 1986 | | 25b. REGISTRAR'S SIGNATURE
John Gordon-Randall | |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 is marked, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The 3 required that the death be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then page 4 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP



James H. Jones, Inc., 1105 Madison St.

Concordville

Pa.

026993 DEC 15 1986

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that a death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

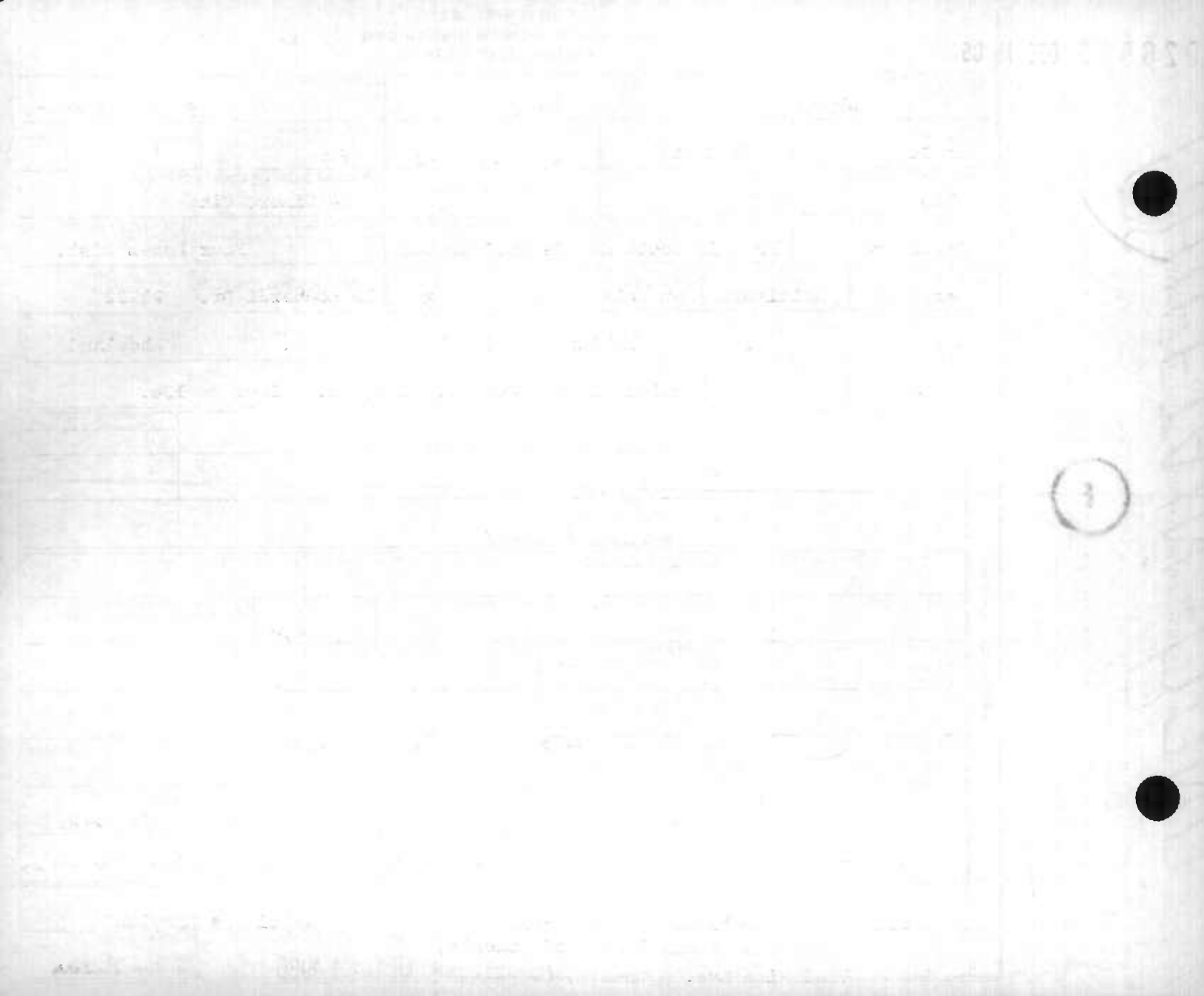
8 6

3 4 0 4 2

REG. NO.

| | | | | | | | |
|--|--|---|---|---|------------------------------|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
<i>Martha Lane</i> | | | 2a. DATE OF DEATH
MONTH DAY YEAR
<i>12 9 86</i> | | 2b. HOUR
<i>5:18 P.M.</i> | | |
| 3. SEX
<i>Female</i> | | 4. RACE
<i>W White</i> | | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>2 23 23</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>63</i> YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>Ohio</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Baltimore City</i> MD. | |
| 10. CITY OR TOWN OF DEATH
<i>Baltimore</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Francis Scott Key Medical Center</i> | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Four</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>Roses Dist.</i> | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
<i>Maryland</i> | | 13b. COUNTY
<i>Baltimore</i> | | 13c. CITY OR TOWN
<i>Dundalk</i> | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>Roy J. Kohler</i> | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>Edith A. Wheeland</i> | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>No</i> | | 16b. SOCIAL SECURITY NO.
<i>218-14-1241</i> | |
| 17. INFORMANT
ADDRESS
<i>John E. Lane, Jr. Same as 13c.</i> | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Cardiopulmonary arrest</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>hypoxia</i>
DUE TO, OR AS A CONSEQUENCE OF (c) <i>intracranial bleed</i> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18; PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>12/7</i> , 19 <i>86</i> , to <i>12/9</i> , 19 <i>86</i> , that (I) (we) lost
saw the deceased alive on <i>12/9</i> , 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<i>Ann L. M. M.</i> | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
<i>12/9/86</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>Ann L. M. M.</i> | | 22e. ADDRESS
<i>FSEMC 4940 Eastern Ave. Baltimore MD 21224</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<i>Burial</i> | | 23b. DATE
<i>12-13-86</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Oak Lawn</i> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Baltimore Maryland</i> | |
| 24. FUNERAL DIRECTOR
NAME
<i>Duda-Ruck Funeral Home of Dundalk</i> | | 25a. DATE REC'D. BY REGISTRAR
<i>DEC 11 1986</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Julia Swenson-Pandey</i> | | | |

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8634043
REG. NO.1 - FOR
STATE
REGISTRAR

| | | | | | | | | | |
|--|--|--|--|---|--|--|---|---|--|
| 1. DECEASED NAME
(Type or print) Sonie | | | 2a. DATE OF DEATH MONTH DAY YEAR
Dec 28, 1986 | | | 2b. HOUR
2:00 PM | | | |
| 3. SEX
F | | 4. RACE
W | | 5. DATE OF BIRTH
MONTH DAY YEAR
Dec 7 1905 | | 6. AGE (IN YEARS LAST BIRTHDAY)
81 YRS | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Baltimore | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore md. MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
1400 Andre St. 21230 | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | | 12b. KIND OF BUSINESS OR INDUSTRY
— | |
| 13a. STATE
md. | | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Adam | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Morrison | | | 13e. STREET ADDRESS / ZIP CODE
1400 Andre St. 21230 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | | 16b. SOCIAL SECURITY NO.
217-224454 | | 17. INFORMANT
ADDRESS
Marion Shepre 21222 nd. 1714 Pinewood Drive | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiopulmonary arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) Levin Metastasis
DUE TO, OR AS A CONSEQUENCE OF
(c) Carcinoma of the Gallbladder. | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: — | | | | | | | | | |
| 19a. DATE OF OPERATION
— | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
— | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. — 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
— | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
— | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
— | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Sept , 19 83 , to Dec 28 , 19 86 , that (I) (we) last
saw the deceased alive on Dec 27 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Sandra L. Howard M.D. | | | | | | DEGREE
M.D. | | 22c. DATE SIGNED
Dec 28, 1986 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Sandra L. Howard M.D. | | | | | | 22e. ADDRESS
1600 S. Charles St. 21230 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(Type or print)
Burial | | | 23b. DATE
12/31/86 | | 23c. NAME OF CEMETERY OR CREMATOR
Louisa Park Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Federal Hill Md. | | |
| 24. FUNERAL DIRECTOR
NAME
Charles L. Hovis Funeral Home | | | | | | 25. DATE REC'D. BY REGISTRAR
DEC 30 1986 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 2 and 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director. Page 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

SEP 2 1964

203 C-10N FIELD



CHIEF X/M
DOWN

SEP 2 1964

TO HOSPITAL OR ATTENDING PHYSICIAN: The low required that certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|--|--|---|--|
| 1- FOR STATE REGISTRAR
Dorothy Marie Langellotto | | | | | | | | | | | |
| 1a. DECEASED NAME (TYPE OR PRINT)
Dorothy | | | 2a. DATE OF DEATH
12 4 86 | | | 2b. HOUR 7:10 P.M. | | | | | |
| 3. SEX
Female | | | 4. RACE
Cauc. | | | 5. DATE OF BIRTH
11 13 35 | | | 6. AGE (IN YEARS LAST BIRTHDAY)
51 YRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Balto., Md. | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Mercy Hospital | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | | 12b. KIND OF BUSINESS OR INDUSTRY
- | | |
| 13a. STATE
Md. | | | 13b. COUNTY
- | | | 13c. CITY OR TOWN
Balto. | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
John E. Adams | | | 15. MOTHER'S MAIDEN NAME
Marie H. Croucher | | | 13e. STREET ADDRESS / ZIP CODE
4904 Midline Rd. 21206 | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO.
219-30-6875 | | | 17. INFORMANT ADDRESS
Daniel Langellotto, husband, same add. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) METASTATIC BREAST CARCINOMA
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4 YEARS | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) _____ | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/11/86 to 12/14/86, that (I) (we) lost saw the deceased alive on 12/11/86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Dana J.P. Phillips, MD | | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
12/14/86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DANA J.P. PHILLIPS, MD | | | | | | 22e. ADDRESS
Mercy Hospital 301 ST PAUL PLACE | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
12/9/86 | | | 23c. NAME OF CEMETERY OR CREMATORY
Sacred Heart of Jesus | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto., Md. | | |
| 24. FUNERAL DIRECTOR
Schnitzler Funeral Home, Inc.
3331 Brehms Lane, Balto., Md. 21213 | | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 8 1986 | | | 25b. REGISTRAR'S SIGNATURE | | |

100-100000

100-100000



029455 JAN 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | |
|--|---------|------------------|--|---|------------------|--|--|---|---|--------------------------------------|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a. DATE KNOWN OF DEATH ESTIMATED | | | | 2b. HOUR | | | | |
| Mary | | | B LaRogue | | | <input checked="" type="checkbox"/> MONTH DAY YEAR
<input type="checkbox"/> 12 29 19 86 | | | | M | | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) | IF UNDER 1 YR. | IF UNDER 24 HRS. | 7c. DATE PRONOUNCED DEAD | | | | 7d. HOUR | | | | |
| Female | White | Nov. 11, 1918 | 68 YRS. | MONTHS | DAYS | 12 29 19 86 | | | | 4:19 PM | | | | |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | |
| Pennsylvania | | | USA | | | Baltimore City, MD. | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| Baltimore | | | University Hospital | | | Retired | | | | Civil Service | | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| 13a. STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? | | | 13e. STREET ADDRESS | | |
| MD | | | AA | | | Arnold | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 349 Volley Road - 21012 | | |
| 14. FATHER'S NAME | | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | ADDRESS | | |
| Charles Biever | | | | | | Caroline Gerlach | | | | | | 1231 Sequoia Rd | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | 17. ADDRESS | | |
| Yes | | | | | | 188-10-9718 | | | Lawrence Zmuda | | | 1231 Sequoia Rd | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 1 DEATH WAS CAUSED BY: | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Multiple injuries | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last | | | | | | | | | | | | | | |
| (b) | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? | | |
| | | | | | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | |
| | | | | 1:59 AM 12 29 19 86 | | | | Driver in auto/auto impact | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION | | | | | | |
| | | | | street | | | | Rt. 2 & Hahn Dr. Anne Arundel, MD. | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | TITLE (SPECIFY) | | | | DATE SIGNED | | | | | | |
| | | | | M.D. Assistant | | | | 12/30/86 | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS | | | | | | | | | | |
| William M. Zane, M.D. | | | | 111 Penn St. Balto. MD. | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION | | |
| Burial | | | | Jan 3, 1987 | | | | Holy Cross Cemetery | | | | Lebanon PA | | |
| 24. FUNERAL DIRECTOR | | | | ADDRESS | | | | 25a. DATE REC'D BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | |
| Taylor Funeral Chapel | | | | Annapolis, MD | | | | JAN 5 1987 | | | | Julia Trivison-Randall | | |

DIVISION OF VITAL RECORDS, 281 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 281 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MBP
DHMH - 17
(VR A15 ME (5))

029227 JAN - 5 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | |
|---|--|---|--|--|--|---|--|--|------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
MARY L. LAWSON | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 26 86 | | | 2b. HOUR
6 PM | | | | |
| 3. SEX
Female | | 4. RACE
BLACK | | 5. DATE OF BIRTH
MONTH DAY YEAR
11 28 10 | | 6. AGE (IN YEARS LAST BIRTHDAY)
76 YRS. | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Georgia | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
City MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Mercy Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md. | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
1214 Light St. 21230 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Gene Mims | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Henietta Mimss | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT
ADDRESS
Mattie L. Beal 3068 Ascension St 21225 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Pneumonia</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Squamous Cell Carcinoma of Esophagus</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
6 DAYS | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a.
<u>GASTROINTESTINAL BLEEDING</u> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12-25</u> 19 <u>86</u> , to <u>12/26</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>12/25</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<u>Robert C. Greenwell Jr. MD</u> | | | | | DEGREE
MD | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
12-26-86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ROBERT C. GREENWELL JR. MD | | | | | 22e. ADDRESS
Mercy Hospital 301 St. Paul Place | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(CHECK ONE)
Burial | | | 23b. DATE
12/30/86 | | 23c. NAME OF CEMETERY OR CREMATORY
Meadowridge Park | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Elkridge Md. | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Chas. A. Rice FSPA 1300 Eutaw Place | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 31 1986 | | 25b. REGISTRAR'S SIGNATURE
<u>Julia Davidson</u> | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

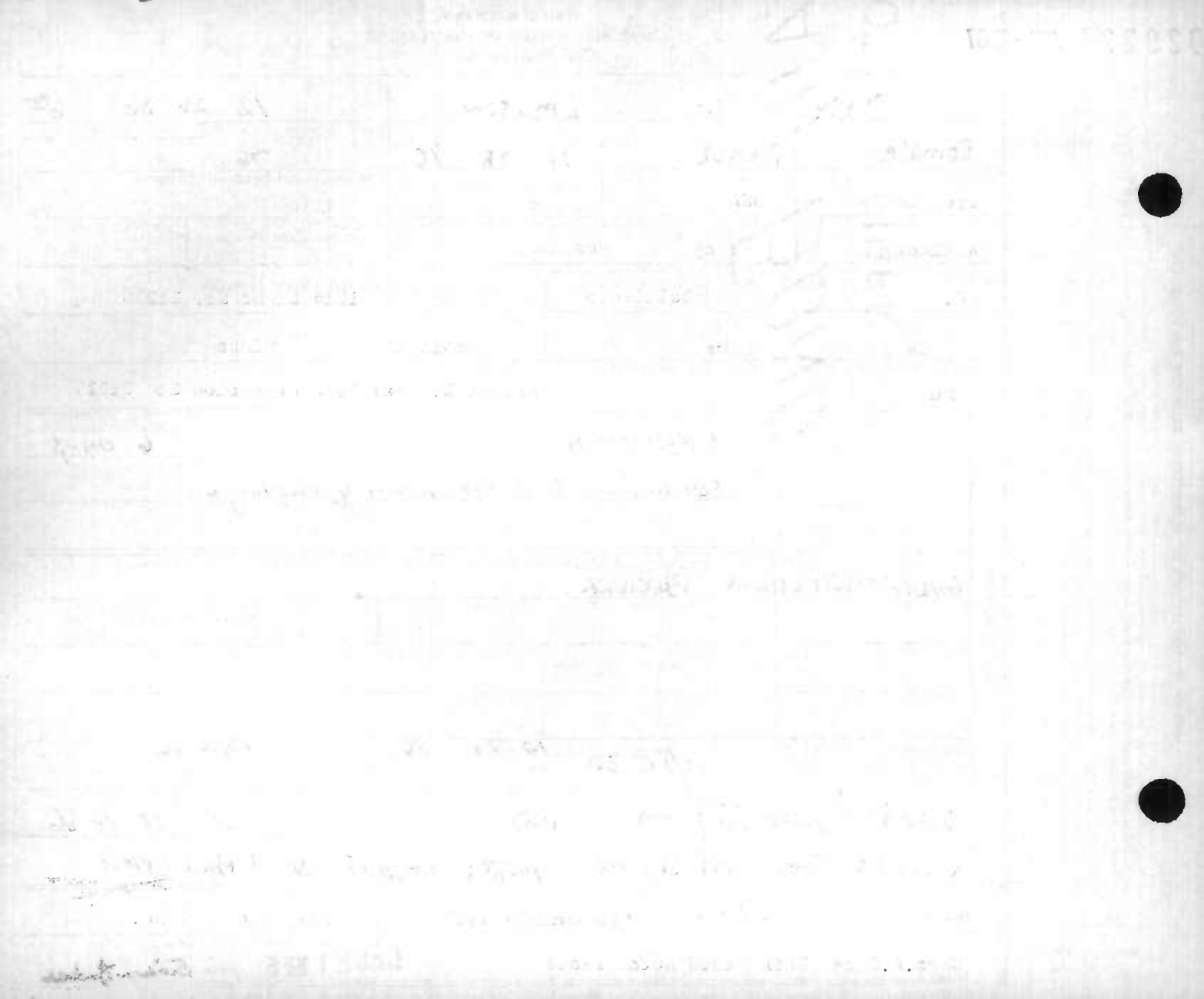
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it may be retained by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

MEDICAL CERTIFICATION

BP.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please register this paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other unusual event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
James Edward LEE, Sr. | | 2a. DATE OF DEATH
MONTH DAY YEAR
December 28, 1986 | | 2b. HOUR
8:31M | |
| 3. SEX
Male | 4. RACE
Black | 5. DATE OF BIRTH
MONTH DAY YEAR
12 22 1942 | | 6. AGE (IN YEARS LAST BIRTHDAY)
44 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Maryland General Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Laborer | | 12b. KIND OF BUSINESS OR INDUSTRY
Machinst Co. |
| 13a. STATE
Maryland | | 13b. COUNTY
Baltimore | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Francis M. Lee | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Pauline Thomas | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No. | | 16b. SOCIAL SECURITY NO.
217-40-7124 | | 17. INFORMANT
Baltimore, Maryland 21216
Phyllis W. Lee 1608 St. Stephens Street | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac arrest

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Renal failure
(c) Pulmonary edema | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: H T L V III+ Positive Test Antibody | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from December 15, 19 86 to December 28, 19 86 , that I (we) last saw the deceased alive on December 28, 19 86 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (didn't) view the body after death. | | | | | |
| 22b. SIGNATURE
Darab Hormozi, M.D. | | DEGREE
M.D. | | 22c. DATE SIGNED
12/29/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Darab Hormozi | | 22e. ADDRESS
c/o Maryland General Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
1/03/1987 | | 23c. NAME OF CEMETERY OR CREMATORY
Arbutus Memorial Park | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Maryland | | 23e. DATE REC'D. BY REGISTRAR
JAN 6 1987 | | | |
| 24. FUNERAL HOME, INC.
NAME ADDRESS
2501 Gwynns Falls Pkwy. Baltimore, Md. 21216 | | 25. REGISTRAR'S SIGNATURE
Julia Tindon-Randall | | | |

100-10-10000

1

028435 DEC 30 1986

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 6 3 4 5 4 8

| | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|--------------------------------------|--|---|--|---------------|--|---|--|---|--|---|--|--|--|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | 2a. DECEASED NAME
(TYPE OR PRINT) | | FIRST
Kenneth | | MIDDLE
Lee | | LAST | | 7a. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR | | 12 16 19 86 | | 7b. HOUR
M | | | | | | | | | |
| 3. SEX
M | | 4. RACE
B | | 5. DATE OF BIRTH
MONTH DAY YEAR | | 8/16/40 | | 6. AGE (IN YEARS LAST BIRTHDAY)
46 YRS. | | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN | | 7c. DATE PRONOUNCED DEAD
MONTH DAY YEAR | | 12 19 19 86 | | 7d. HOUR
P M | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Balto., Md. | | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD. | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
2077 Woodborne Avenue | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Locke Insulators | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13a. STATE
Md. | | | | 13b. COUNTY | | | | 13c. CITY OR TOWN
Balto. | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 13e. STREET ADDRESS
2077 Woodbourne Ave. | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Raymond Layton | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Elizabeth Lee | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
no | | | | 16b. SOCIAL SECURITY NO.
220-36-8547 | | | | 17. INFORMANT
Elizabeth Williams 501 E. Preston | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>William M. Zane</u> | | | | TITLE (SPECIFY)
M.D. Assistant MEDICAL EXAMINER | | | | DATE SIGNED 12/23/86 | | | | | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT)
William M. Zane, M.D. | | | | ADDRESS
111 Penn St. Balto. MD. | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | 23b. DATE
12/24/86 | | | | 23c. NAME OF CEMETERY OR CREMATORY
King Mem. Park | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto., Md. | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Leroy O. Dyett 4600 Liberty Heights | | | | ADDRESS | | | | 25a. DATE REC'D BY REGISTRAR
DEC 29 1986 | | | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | | | | | | | | | | |

07/84
25MBP
DHMH - 17
(VR A15 ME (5))

100% COTTON
WELLS

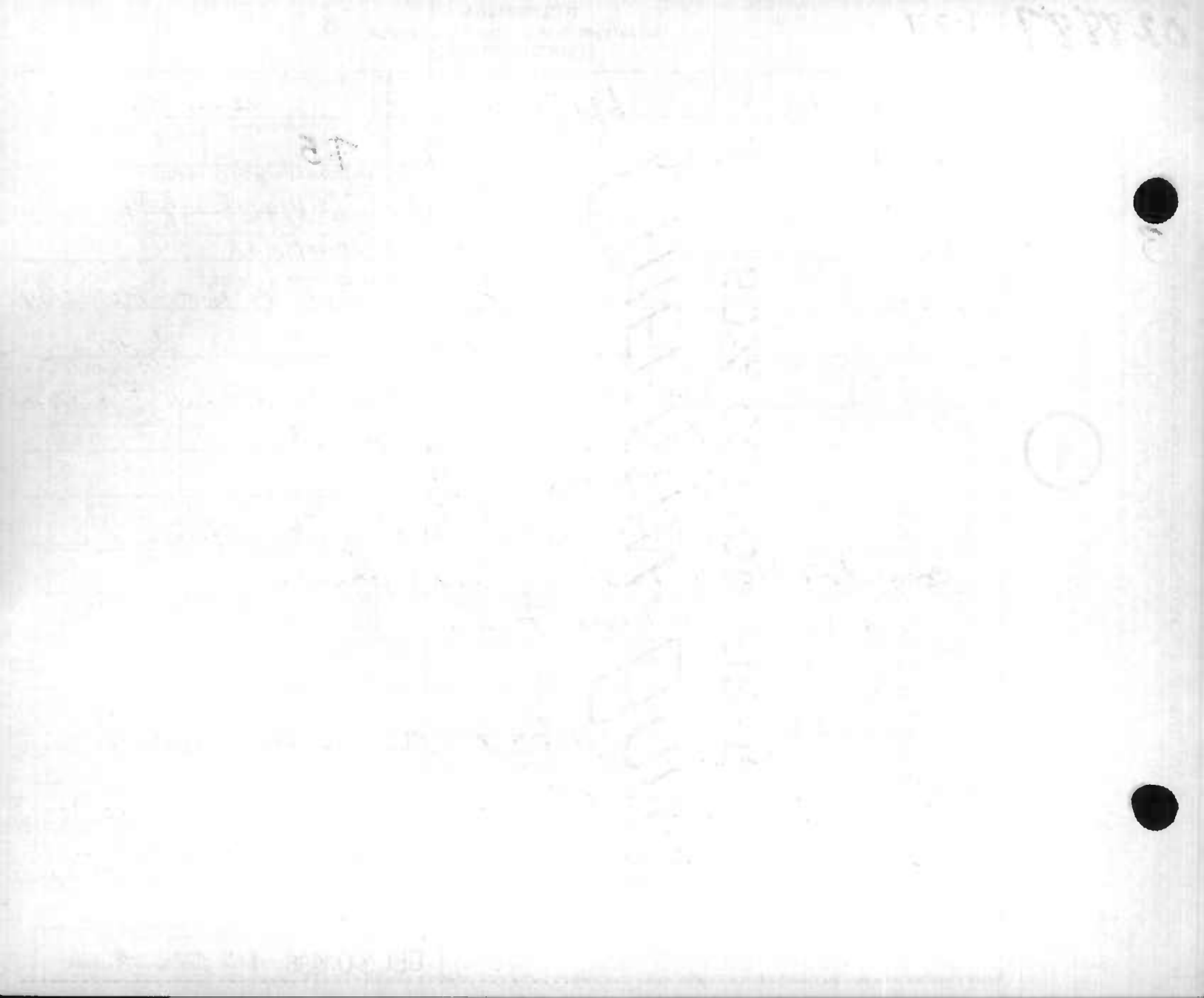


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove (detach) page 1 and 2, should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition. **IMPORTANT:** If item 21 is marked or item 18 shows any injury, or other traumatic event, a medical examiner must be called at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) <u>Vertel LEFTWICH</u> | | | | 2a. DATE OF DEATH MONTH <u>12</u> DAY <u>24</u> YEAR <u>86</u> | | | |
| 3 SEX <u>Female</u> | | 4. RACE <u>Black</u> | | 5. DATE OF BIRTH MONTH <u>2</u> DAY <u>10</u> YEAR <u>11</u> | | 2b. HOUR <u>3:35</u> P M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Va.</u> | | 7b. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 6. AGE (IN YEARS LAST BIRTHDAY) <u>45</u> YRS | | IF UNDER 1 YEAR MONTHS <u></u> DAYS <u></u> | |
| 10 CITY OR TOWN OF DEATH <u>Baltimore</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Liberty MED Center</u> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore City</u> MD. | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Unemployed</u> | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE <u>MD</u> | | 13b. COUNTY <u>Baltimore</u> | | 13c. CITY OR TOWN <u>Baltimore</u> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14 FATHER'S NAME FIRST <u>William</u> MIDDLE <u></u> LAST <u>Leftwich</u> | | 15 MOTHER'S MAIDEN NAME FIRST <u>Nannie</u> MIDDLE <u></u> LAST <u>Walter</u> | | 13e. STREET ADDRESS / ZIP CODE <u>3314 W. North Ave 21216</u> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u> | | 16b. SOCIAL SECURITY NO. <u>Unknown</u> | | 17 INFORMANT ADDRESS <u>Virgious Leftwich Chatham Rte 6 Box 153 Pittsylvania Co. Va.</u> | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardio pulmonary arrest</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Septicemia</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Endotracheal bleeding, fecal fistula</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Congestive Heart Failure, Renal failure</u> | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION <u>12-5-86</u> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Small bowel fistula</u> | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>11-01-86</u> P.M. <u>19</u> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11-01-86</u> to <u>12-24</u> 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>12-24</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 23a. SIGNATURE <u>James E. Mathew MD</u> DEGREE <u>M.D.</u> | | | | 23b. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 23c. DATE SIGNED <u>12/24/86</u> | |
| 24. FUNERAL DIRECTOR NAME <u>Wm C March F/H West</u> ADDRESS <u>4300 Wabash Ave.</u> | | | | 25a. DATE REC'D. BY REGISTRAR <u>DEC 30 1986</u> 25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Rodgers</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | 23b. DATE <u>12/29/86</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Union Hall Ch Cem.</u> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>Pittsylvania, Va.</u> | |

BP _____



029513 JAN 19

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 3 4 6 5 0

REG. NO.

| | | | | | | | |
|---|---|--|--|---|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT) Robert Lenon- | | | 2a. DATE OF DEATH MONTH DAY YEAR
12-23-86 | | | 2b. HOUR
6⁰¹ A M | |
| 3. SEX
male- | 4. RACE
Black- | 5. DATE OF BIRTH
MONTH DAY YEAR
02 14 52- | 6. AGE (IN YEARS LAST BIRTHDAY)
34 44/41 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
Virginia- | 7b. CITIZEN OF WHAT COUNTRY?
U.S.- | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore County CITY MD | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore- | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
University Hospitals Hospital | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Unemployed | | 12b. KIND OF BUSINESS OR INDUSTRY
None | |
| 13a. STATE
M.D | | 13b. COUNTY
Baltimore | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
Box 534 20794- | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Donna A. Adams | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Donna A. Adams | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
159-46-4709 | | 17. INFORMANT ADDRESS | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Compromised myocardium -
DUE TO, OR AS A CONSEQUENCE OF
(b) Unknown, Chronic renal failure -
DUE TO, OR AS A CONSEQUENCE OF
(c) AIDS | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: AIDS | | | | | | | |
| 19a. DATE OF OPERATION
12/19/86 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/19/86 19 86 , to 12/23 19 86 , that (I) (we) last saw the deceased alive 12/23 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death. | | | | | | | |
| 22b. SIGNATURE
J. Cavallos MD | | | | DEGREE
MD | | 22c. DATE SIGNED
12/23/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
J. Cavallos MD | | | | 22e. ADDRESS
22 S. Greene Street Baltimore | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Removal | | 23b. DATE
12-29-86 | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | |
| 24. FUNERAL DIRECTOR
NAME
Anatomy Board | | | | ADDRESS
Balto., Md. | | 25a. DATE REC'D. BY REGISTRAR
JAN 08 1987 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

100-1100

100% COTTON

26245 DEC-86

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 3465

REG. NO.

| | | | | | | | | | | | |
|--|--|--|--|---|---|---|---|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Roger Thomas Leonard, Sr. | | | 2a. DATE OF DEATH
MONTH 12 DAY 12 YEAR 1986 | | | 2b. HOUR
3:30 PM | | | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH 6 DAY 13 YEAR 11 | | 6. AGE (IN YEARS LAST BIRTHDAY)
75 YRS | | IF UNDER 1 YEAR
MONTHS 7 DAYS 12 | | IF UNDER 24 HRS
HOURS 3 MIN. 30 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Loch Raven Veterans Hospital | | | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
MANU. | | 12b. KIND OF BUSINESS OR INDUSTRY
Paint | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
STATE Ind COUNTY Balto | | | 13c. CITY OR TOWN
Owings Mills | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
69 Fennington Circle 21117 | | | | |
| 14. FATHER'S NAME
FIRST John MIDDLE Leonard LAST Keough | | | 15. MOTHER'S MAIDEN NAME
FIRST Annie MIDDLE Keough LAST Keough | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) yes | | | 16b. SOCIAL SECURITY NO.
215-12-7586 | | 17. INFORMANT
Hilda Leonard | | | ADDRESS
69 Fennington Circle Owings Mills, Md. | | | |

| | | |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hemodynamic Compromise | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
24-48 hours
1 1/2 years |
| DUE TO, OR AS A CONSEQUENCE OF
(b) acute GI bleed | | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) prostate cancer | | |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d)

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Nov 29, 1986 to Dec 2, 1986 , that (I) (we) lost
saw the deceased alive on Dec 2, 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
L. Parkhurst MD | | | | DEGREE | | 22c. DATE SIGNED
12/2/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
LINDA PARKHURST | | | | 22e. ADDRESS
Loch Raven VA Hospital, Loch Raven Road, Balto, | | | |

MEDICAL CERTIFICATION

| | | | | | | | |
|---|--|---------------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) Burial | | 23b. DATE
Dec 5, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY
London Park Cem. | | 23d. LOCATION
CITY OR TOWN Baltimore COUNTY Maryland STATE Md. | |
| 24. FUNERAL DIRECTOR
NAME A. Zehardt ADDRESS Owings Mills, Md. | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 5 1986 | | 25b. REGISTRAR'S SIGNATURE
Robert R. Riddle | |

DIVISION OF VITAL RECORDS, 201 W. PENSION ST., BALTIMORE, MARYLAND 21201



027432 DEC 17 1986

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 34052

| | | | | | | | | | |
|---|---|---|--|--|-----------------------------------|---|------------------|--------|---|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | MONTH | DAY | YEAR | 2b. HOUR |
| ATTILIO Augustino LEVERO | | | | | DECEMBER 12, 1986 | | | | P.M. 7:36 |
| 1. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | |
| Male | White | 6 MONTH 11 DAY 1904 | | 82 | MONTHS DAYS | | HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Italy | U.S.A. | | | Baltimore City | | MD. | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION
(GIVE STREET ADDRESS) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| Baltimore | Church Hospital Inc. | | Operating Engineer | | Steel Mfrgr. | | | | |
| 13a. STATE | | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE | | | | |
| Maryland | | Baltimore | Dundalk | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 246 Riverview Ave./21222 | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | | | | | | |
| Augustine | | Levero | | Sunta | | Salisanta | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES) | | 17. INFORMANT ADDRESS | | | | | |
| No | | 213/09/0078 | | Anna M. Levero (wife) (same as 13e.) | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>CHRONIC LUNG DISEASE</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
<u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET | | CITY OR TOWN | | COUNTY | STATE |
| 22a. I certify that (1) the hospital attended the deceased from <u>DECEMBER 8, 1986</u> to <u>DECEMBER 12, 1986</u> , that (1) (we) last saw the deceased alive on <u>DECEMBER 12, 1986</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.) | | | | | | | | | |
| 22b. SIGNATURE
<u>A. B. Nazemi M.D.</u> | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
<u>12/12/86</u> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
NAZEMI, ATAOLLAH F M.D. | | 22e. ADDRESS
CHURCH HOSPITAL CORPORATION
100 N. BROADWAY BALTIMORE, MD. 21231 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN | | COUNTY | STATE | |
| Burial | | 12/16/1986 | St. Stanislaus Cem. | | Baltimore, Maryland | | 21222 | | |
| 24. FUNERAL DIRECTOR
NAME | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Walter Brooks Bradley Inc. | | Balto., Md. 21222 | | DEC 16 1986 | | <u>Edison B. B. B.</u> | | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

LEVERO, ATTILIO

213 09 0078

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked off item 18 shows any injury, or other traumatic event, the medical examiner may be notified at 1-800-368-1234.

051

ST. JULIA, OREGON
71 - 8700 PM ELS

4 11 11
10 11 11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These pages require carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, either traumatic event, the medical examiner must be visited at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | | |
|---|--|--|---|--|--|--|---|--|--|--|------------------------------|--|
| 1- FOR STATE REGISTRAR | | | | | | | | | | 78034053 | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST
Lewis | | MIDDLE | | LAST
Levy | | 2a. DATE OF DEATH
MONTH DAY YEAR
12/19/86 | | 2b. HOUR
12:39
M | |
| 3 SEX
Male | | | 4 RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
8-16-98 | | 6. AGE (IN YEARS LAST BIRTHDAY)
88
YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | IF UNDER 1 YRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | |
| 10 CITY OR TOWN OF DEATH
Baltimore city | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
North Charles General Hospital | | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Warehouseman | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
Maryland | | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
2531 Pennsylvania Avenue 21211 | | | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
Rubin Levy | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Not Known | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO.
215-10-7891 | | 17. INFORMANT
ADDRESS
Harry E. Schokney Same as 13e | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b and 1c.)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiogenic Shock</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Acute Myocardial infarction</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/17/86</u> to <u>12/19/86</u> , that (we) last saw the deceased alive on <u>12/19/86</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Marcos B. Galicia Jr. MD</u> | | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED
12/19/86 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MARCOS B. GALICIA Jr, MD | | | | | 22e. ADDRESS
North Charles General Hospital | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
Dec. 23, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY
Western Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Maryland | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Leonard J. Ruck, Inc. | | | | | ADDRESS
Baltimore, Maryland | | 25a. DATE REC'D. BY REGISTRAR
DEC 22 1986 | | 25b. REGISTRAR'S SIGNATURE
<u>Julia Davidson-Randall</u> | | | |

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
HERBERT LEWIS | | 2a. DATE OF DEATH
MONTH 12 DAY 22 YEAR 86 | | 2b. HOUR 10 MIN PM | |
| 3. SEX
MALE | | 4. RACE
BLACK | | 5. DATE OF BIRTH
MONTH 11 DAY 23 YEAR 39 | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
M.D. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
LIBERTY MED CENTER | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTO CITY MD. | |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MD | | 13b. COUNTY | | 13c. CITY OR TOWN BALTO | |
| 14. FATHER'S NAME
FIRST John MIDDLE Lewis LAST Lewis | | 15. MOTHER'S MAIDEN NAME
FIRST SARAH MIDDLE GARRETT LAST GARRETT | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
1960-1963 | | 17. INFORMANT
ADDRESS Herbert G. Lewis 4413 Pailmail Rd #2125 | |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) RESP ARREST
DUE TO, OR AS A CONSEQUENCE OF (b) LUNG CANCER
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO, OR AS A CONSEQUENCE OF (c)
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/07 19 86 to 12/09 19 86 that (I) (we) last saw the deceased alive on 12/07 19 86 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
THARMAZ ALIX | | DEGREE | | 22c. DATE SIGNED
12/09/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
THARMAZ ALIX | | 22e. ADDRESS
LIBERTY MED CENTER, BALTO, MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE
12/13/86 | | 23c. NAME OF CEMETERY OR CREMATORY
GARRISON Forest Cem | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Owings Mills Md. | | 23e. DATE REC'D. BY REGISTRAR | | 23f. REGISTRAR'S SIGNATURE | |
| 24. FUNERAL DIRECTOR
NAME Bette Funeral Home ADDRESS 1129 N. Caroline | | 25. DATE DEC'D. BY REGISTRAR DEC 12 1986 | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1917

RECEIVED



1917

029159 JAN

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

| | | | | | | | | | | | | | | | | | |
|--|---------|---|--|---|--|--|--|----------------------------|--|--------------------------------|--|-------|--|------|--|-----------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN
OF DEATH | | MONTH | | DAY | | YEAR | | 7b. HOUR | |
| John | | R. | | Lewis, Jr. | | | | XX | | 12-20 | | 1986 | | | | M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE
PRONOUNCED
DEAD | | MONTH | | DAY | | YEAR | |
| Male | White | Oct. 8, 1958 | | 28 YRS. | | | | | | 12-20 | | 1986 | | | | 1:12 a.m. | |
| 7d. BIRTHPLACE (STATE OR
FOREIGN COUNTRY) | | 7e. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | MD. | |
| Md. | | U.S.A. | | | | Baltimore City, | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS
OR INDUSTRY | | | | | | | | | | | |
| Baltimore | | University Hospital - STU | | Labor. | | Ind. | | | | | | | | | | | |
| 13a. STATE | | 13b. CITY | | 13c. INSIDE CITY LIMITS? | | 13d. STREET ADDRESS | | | | | | | | | | | |
| Md. | | Elkton | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 12 Pine Ave. 21921 | | | | | | | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | |
| John H. Lewis | | Janet Rea | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | 12. Pine Ave. | | | | | | | | | | | |
| No | | 219-90-3839 | | John H. Lewis | | Elkton, Md. 21921 | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Multiple Injuries
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) DUE TO, OR AS A CONSEQUENCE OF
(c) DUE TO, OR AS A CONSEQUENCE OF | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | |
| 8147 | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | | | | | | | | | | | | | |
| | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input checked="" type="checkbox"/> OR
CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR <input checked="" type="checkbox"/> MONTH DAY YEAR
7:25 P.M. 12-19 1986 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | |
| | | | | pedestrian struck by auto | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.)
road | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
Sykesville Road north of Freedom Ave., West-
minster, Carroll Co. Md. | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | TITLE (SPECIFY)
M.D. Assistant MEDICAL EXAMINER | | DATE SIGNED 12-20-86 | | | | | | | | | | | |
| ACTUAL
SIGNATURE | | EXAMINER'S NAME
(TYPE OR PRINT) | | ADDRESS | | | | | | | | | | | | | |
| William M. Zane, M.D. | | 111 Penn St., Balto., Md. 21201 | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| Burial | | 12-26-86 | | North East Meth. Cem. | | North East Cecil Md. | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | |
| Groun Funeral Home North East, Md. | | 12-30-1986 | | John Zane | | | | | | | | | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT, PAGE 5, AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP
DHMH - 17
(VR A15 ME (5))

NOV 21 1980



029124 JAN - 5187

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | |
|--|--|---|---|
| 1. DECEASED NAME
JOSEPHINE
JOSEPHINE | | 2. DATE OF DEATH
Dec. 12 23 86
4:00pm | |
| 3. SEX
Female | 4. RACE
Black | 5. DATE OF BIRTH
January 31, 1890
01 31 90 | 6. AGE (IN YEARS LAST BIRTHDAY)
96 YRS. |
| 7a. BIRTHPLACE
Newport, VA | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD. |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
3605 Fairview Ave. Balto., Md | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
Maryland | | 13b. COUNTY | 13c. CITY OR TOWN
Baltimore |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William Parker | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Rachel | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
243-64-5727 | |
| 17. INFORMANT
ADDRESS
Ophelia Hargrove 3605 Fairview Ave. 21216 | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) <u>Atherosclerotic Cardiovascular disease</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____ | |
| 19a. DATE OF OPERATION
12-22-86 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Thromb Valve | |
| 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22. I certify that (I) (this hospital) attended the deceased from 12. 12. 19 85 to 12. 12. 19 86, that (I) (we) last saw the deceased alive on 12. 12. 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
DARSHAN S. SALUJA MD | | 22c. DATE SIGNED
1600 MT Royal Ave, Balto 21217 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
12-28-86 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Franklin Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Franklin Va. | |
| 24. FUNERAL DIRECTOR
NAME
Marshall W. Jones, Jr. FH 4101 Edmondson Ave. | | 25a. DATE REC'D. BY REGISTRAR
JAN - 2 1987 | |
| 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been filed, it should be detached for use as the burial-transit permit. It should be detached for use as the burial-transit permit. It should be detached for use as the burial-transit permit. It should be detached for use as the burial-transit permit.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified of once.

02812

12-23-12

and

January 1, 1913

1913

Dec.

January 1, 1913

also

also

also one 017

also

also one 017

also one 017

also one 017

also

also one 017

also one 017

also one 017

also

also

also

also one 017

also

1913

also

also

also

also

also one 017

also one 017

029245 JAN - 5 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|--|---|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Anna Mo Liebaugh | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12/23/86
HOUR MIN
6:10 PM | | |
| 3. SEX
FE MALE | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
1 6 1901 | 6. AGE (IN YEARS LAST BIRTHDAY)
85
YRS. MONTHS DAYS HOURS MIN. | | |
| 7a. PLACE OF BIRTH (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | |
| 10. CITY OR TOWN OF DEATH
Baltimore city | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
North Charles General Hospital | | 11a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Stenographer | | 11b. KIND OF BUSINESS OR INDUSTRY
Glass Co. |
| 12. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
12a. STATE
Maryland | | | 12b. COUNTY
Baltimore | 12c. CITY OR TOWN
Baltimore | |
| 13a. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13b. STREET ADDRESS / ZIP CODE
5243 Reisterstown Road 21215 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Charles Liebaugh | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Elizabeth Halbig | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
213-05-2985 | | 17. INFORMANT ADDRESS
Anna Liebaugh 5243 Reisterstown Road Balt, MD. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Shock
DUE TO, OR AS A CONSEQUENCE OF
(b) overwhelming sepsis
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I
Respiratory Failure - Acute Renal Failure, Congestive Heart Failure | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
11 P.M. 12 19 86 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/22 19 86 to 12/23 19 86 , that I (we) last saw the deceased alive on 12/23 19 86 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Marcos B. Galicia Jr., MD | | | DEGREE
MD | | 22c. DATE SIGNED
12/23/86 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MARCOS B. GALICIA Jr., MD | | | 22e. ADDRESS
North Charles General Hospital | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
12-27-86 | | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park Cemetery | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Maryland | | 24. FUNERAL DIRECTOR
NAME ADDRESS
MARZULLO FUNERAL SERVICE INC. BALTIMORE, MD | | | |
| 25a. DATE REC'D. BY REGISTRAR
DEC 31 1986 | | 25b. REGISTRAR'S SIGNATURE
John Anderson-Randall | | | |

MEDICAL CERTIFICATION

29

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

124

Group 1: 100% (100%)

CONFIDENTIAL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that physicians indicate the cause of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the following pages. Page 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | REG. NO. | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)
EDWARD (L.) LIGGINS | | | | 2a. DATE OF DEATH MONTH DAY YEAR
DECEMBER 13, 1986 | | | |
| 3. SEX
MALE | | 4. RACE
BLACK | | 5. DATE OF BIRTH
MONTH DAY YR
6 7 30 | | 6. AGE (IN YEARS LAST BIRTHDAY)
56 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE JOHNSHOPKINS HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
BETH. STEEL | | 12b. KIND OF BUSINESS OR INDUSTRY
DISAB. | |
| 13a. STATE
MD | | | | 13b. COUNTY
BALTO. | | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
THOMAS LIGGINS | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
HELEN JACKSON | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
YES | | | | 16b. SOCIAL SECURITY NO.
213268421 | | 17. INFORMANT ADDRESS
JANIE LIGGINS FREELAND 2810 KENNEDY | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>chronic obstructive pulmonary disease</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Approximate interval between onset and death: <u>0 minutes</u>
<u>10 years</u> | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/9</u> , 19 <u>86</u> , to <u>12/13</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>12/13</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>AM V KLION</u> | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
12/13/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
AM V KLION | | | | 22e. ADDRESS
600 N. Wolfe St. Balto. MD. 21205 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
12 19-86 | | 23c. NAME OF CEMETERY OR CREMATORY
GARRISON FOREST | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
OWINGS MILLS MD | |
| 24. FUNERAL DIRECTOR
NAME
MARCH FUNERAL HOME 1101 E. NORTH AVE. | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 18 1986 | | 25b. REGISTRAR'S SIGNATURE
<u>John Fisher</u> | |

42

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain papers, page 2, which should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked for item 18 shows any injury, or other traumatic event, the medical examiner should be called in.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

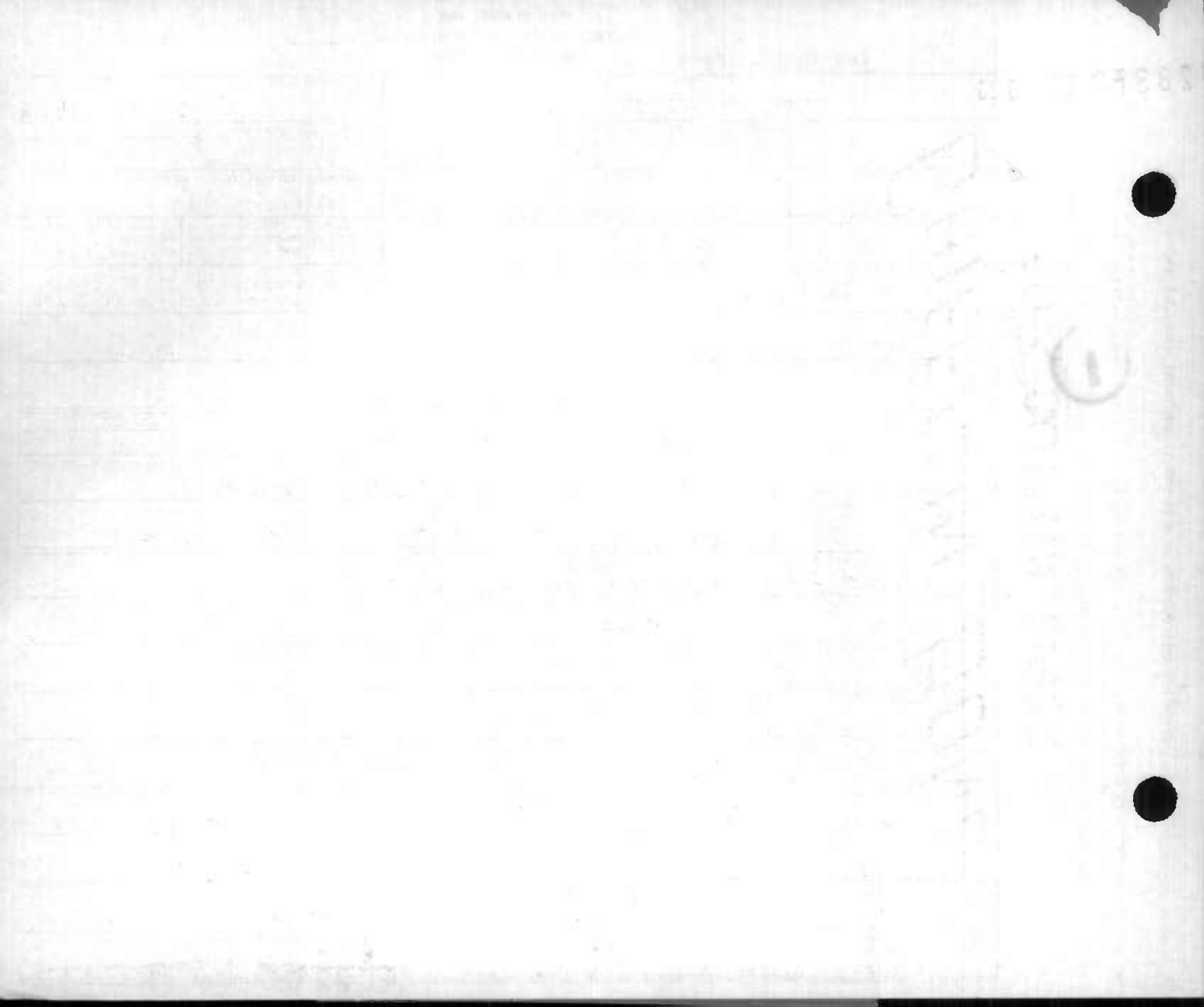
8 0 3 4 0 5 9

1- FOR STATE REGISTRAR
EDMUND A. LIND

CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|---|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
EDMUND ALOYSIO LIND | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 19 86 | | | 2b. HOUR
2:45 PM | |
| 3 SEX
Male | | 4 RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
October 4, 1902 | | 6. AGE (IN YEARS LAST BIRTHDAY)
84 YRS | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
St. Agnes Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Engineer | | 12b. KIND OF BUSINESS OR INDUSTRY C. & P. Telephone Co. | |
| 13a STATE
Maryland | | 13b COUNTY
Baltimore | | 13c CITY OR TOWN
Catonsville | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
Michael Lind | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Bridgett Reagan | | 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | 16b SOCIAL SECURITY NO.
212-03-6065 | |
| 17. INFORMANT
Annette Lind | | ADDRESS
Same as # 13 | | 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>ADENOCARCINOMA OF GALL BLADDER</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>METASTATIC G.B. CARCINOMA TO CBD CAUSING OBSTRUCTION</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>PATIENT HAD HEPATO-RENAL FAILURE 2° TO B+C.</u> | | | | | | | |
| 19a. DATE OF OPERATION
12/12/86 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
B+C ABOVE | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>12/12</u> , 19 <u>86</u> , to <u>12/19</u> , 19 <u>86</u> , that (1) (we) last saw the deceased alive on <u>12/19/86</u> , 19 <u>86</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>Michael J. Macor</u> | | | | DEGREE
<u>M.D.</u> | | 22c. DATE SIGNED
<u>12/19/86</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>DR. MICHAEL MACOR</u> | | | | 22e. ADDRESS
<u>900 CATON AVE BALTIMORE MD 21229</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
12/23/86 | | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Maryland | |
| 24. FUNERAL DIRECTOR
<u>Leroy M. & Russell C. Witzke</u> | | | | 25a. DATE REC'D. BY REGISTRAR
<u>DEC 28 1986</u> | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | |
| 1630 Edmondson Avenue, Catonsville, MD. 21228 | | | | | | | |



028774 DEC 31

66 FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 0 3 4 0 6 0

| | | | | | | | | | | | |
|---|--|---|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST
GEORGE | | MIDDLE
W. | | LAST
LINDEMAN | | 2a. DATE OF DEATH
MONTH DAY YEAR
DECEMBER 25, 1986 | | 2b. HOUR
12:50
P M | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Dec. 15, 1912 | | 6. AGE (IN YEARS LAST BIRTHDAY)
74
YRS | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Baltimore, Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE JOHNS HOPKINS HOSPITAL | | | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Exterminator | | 12b. KIND OF BUSINESS OR INDUSTRY
Terminix Co. | |
| 13a. STATE
Md. | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
106 N. Luzerne Ave.-21224 | | | |
| 14. FATHER'S NAME
FIRST George MIDDLE Lindeman LAST | | | | 15. MOTHER'S MAIDEN NAME
FIRST Helen C. MIDDLE Smith LAST | | | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, IN OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | | |
| 16b. SOCIAL SECURITY NO.
21201-1601 | | | | 17. ADDRESS
Wife: 106 N. Luzerne Ave.-Balto;
Mrs. Catherine M. Lindeman-Md.21224 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) LIVER FAILURE
DUE TO, OR AS A CONSEQUENCE OF (b) ALCOHOL ABUSE
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c)
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: RENAL INSUFFICIENCY | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
24 YEARS
40 YEARS | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (this hospital) attended the deceased from 11/28 19 86, to 12/25 19 86, that (I) (we) last saw the deceased alive on 12/25 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death.) | | | | | | | | | | | |
| 22b. SIGNATURE
Earl Heard | | | | DEGREE
MD | | | | 22c. DATE SIGNED
12/25/86 | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Dr Earl Heard | | | | 22e. ADDRESS
600 N. Wolfe St. 21205
Johns Hopkins Hospital | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
12/29/86 | | 23c. NAME OF CEMETERY OR CREMATORY
Meadowridge Memorial | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Park-Howard Cnty, Md. | | | | | |
| 24. FUNERAL DIRECTOR
John A. Moran, Inc. Funeral Home
3000 E. Baltimore St., Balto., Md. 21224 | | | | DATE REC'D. BY REGISTRAR
DEC 29 1986 | | | | 25. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | | |

MEDICAL CERTIFICATION

9

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition. Page 4 and 2 should be filed with the 24 hours after death. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, the medical examiner must be notified.

26184 DEC-5 1986

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6

3 4 5 6 1

REG. NO.

| | | | | | | | | | | |
|---|--|---|--|---|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Catherine E. Lindenberg | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12/3/86 | | | 2b. HOUR
5:55 A M | | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
2 8 1894 | | 6. AGE (IN YEARS LAST BIRTHDAY)
92 YRS | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore city MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore city | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
North Charles St. Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Saleslady-Bakery | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
Md. | | | 13b. COUNTY
Balto. | | 13c. CITY OR TOWN
Balto. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
Pimlico Manor Nursing Home 21215 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
? Uhler | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
UNKNOWN | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO.
219-16-9014 | |
| 17. INFORMANT
3321 Ryerson Circle-Balto., Md.
Mrs. Nancy M. Jones #21227 | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) pneumonia
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/24/86 to 12/3/86, that (we) last saw the deceased alive on 12/3/86 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (do) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Marcos B. Galicia Jr., MD | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED
12/3/86 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MARCO B. GALICIA Jr., MD | | | 22e. ADDRESS
North Charles GEN. Hospital | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
Dec. 5, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY
New Cathedral Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto. MD. | | | |
| 24. FUNERAL DIRECTOR
G. Truman Schwab | | | 3512 Frederick Ave.
ADDRESS
#21219 | | | 25a. DATE REC'D. BY REGISTRAR
DEC 4 1986 | | 25b. REGISTRAR'S SIGNATURE
Julia Anderson-Lindenberg | | |

MEDICAL CERTIFICATION

29

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other troubling event, the medical examiner must be notified at once.

20% COUON 1983

CHIEF OF BUREAU

29215 JAN -58

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 3 4 0 0 2

REG. NO.

| | | | | | | | |
|--|--|--|--|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
Hattie K. Link | | | 2a. DATE OF DEATH MONTH DAY YEAR
12 26 86 | | | 2b. HOUR
4:30A _M | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MO TH DAY YEAR
12 19 1897 | | 6. AGE (IN YEARS LAST BIRTHDAY)
89 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
Long Green Nursing Home | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | |
| 13a. STATE
Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Joseph J. Kimmel | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Rose Weiler | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
no | | | |
| 16b. SOCIAL SECURITY NO.
219-12-9357 | | 17. INFORMANT ADDRESS
Mrs. Mary Helen Gisriel 5419 St. Albans Way 21212 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Urosepsis</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Urinary Tract Infection</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>3 days</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 <u>59</u> , to <u>12-26</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>12-24</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not see the body after death. | | | | | | | |
| 23a. SIGNATURE
<u>J B Littleton MD</u> | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12-26-86 | |
| 23b. PHYSICIAN'S NAME (TYPE OR PRINT)
J B LITTLETON | | | | 22e. ADDRESS
1012 Old North Bent Rd | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | 23b. DATE
12-27-86 | | 23c. NAME OF CEMETERY OR CREMATORY
Green Mount Crematory | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore MD. | |
| 24. FUNERAL DIRECTOR
NAME
Mitchell-Wiedefeld | | | | ADDRESS
6500 York Rd. | | 25a. DATE REC'D. BY REGISTRAR
DEC 31 1986 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
<u>A. J. ...</u> | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

028116 DEC 25 1986

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

NAPOLEON

LIPSCOMB

2a. DATE KNOWN OF DEATH ☒ MONTH DAY YEAR 2b. HOUR
ESTIMATED ☐ 12-13-86 1 AM

3. SEX
Male

4. RACE
Black

5. DATE OF BIRTH
MONTH DAY YEAR
4 9 27

6. AGE (IN YEARS)
LAST BIRTHDAY
59 YRS.

IF UNDER 1 YR.
MONTHS DAYS HOURS MIN

IF UNDER 24 HRS.
HOURS MIN

7c. DATE PRONOUNCED DEAD 12-13-86 1 AM

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md.

7b. CITIZEN OF WHAT COUNTRY?
USA

8. MARRIED ☒ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD.

10. CITY OR TOWN OF DEATH
Baltimore

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN HOSPITAL, GIVE STREET ADDRESS)
1211 Edmondson Avenue

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md.

13b. COUNTY
Balto.

13c. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET ADDRESS
1211 Edmondson Avenue 21223

14. FATHER'S NAME
FIRST MIDDLE LAST

15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)
No

16b. SOCIAL SECURITY NO.
N/A

17. INFORMANT
ADDRESS
Joan Wiggins 526 N. Carrollton Avenue

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cirrhosis of liver
DUE TO, OR AS A CONSEQUENCE OF

(b) chronic alcoholism
DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?
YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION
STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (TYPE OR PRINT)
John E. Smialek, M.D.

TITLE (SPECIFY)
M.D. Chief MEDICAL EXAMINER
DATE SIGNED 12-14-86

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial

23b. DATE
12/19/86

23c. NAME OF CEMETERY OR CREMATORY
Mt Zion Cemetery

23d. LOCATION
CITY OR TOWN COUNTY STATE
Lansdown Md

24. FUNERAL DIRECTOR
NAME
March Funeral Home West 4300 Wabash Avenue

ADDRESS

25a. DATE REC'D. BY REGISTRAR
DEC 23 1986

25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25M

BP
DHMH - 17
(VR A15 ME (5))

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

Handwritten notes and signatures, including a large signature at the bottom right.

027541

DEC-18-86
FOR
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|--|---|--|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST <u>Berneta</u> MIDDLE <u>Irene</u> LAST <u>Little</u> | | | 2a. DATE OF DEATH
MONTH <u>12</u> DAY <u>15</u> YEAR <u>86</u> | | 2b. HOUR
<u>0911 PM</u> |
| 3. SEX
<u>Female</u> | 4. RACE
<u>White</u> | 5. DATE OF BIRTH
MONTH <u>11</u> DAY <u>25</u> YEAR <u>08</u> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<u>78</u> YRS. | IF UNDER 1 YEAR
MONTHS <u></u> DAYS <u></u> |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<u>MD Penna.</u> | 7b. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<u>Baltimore</u> City MD. | |
| 10. CITY OR TOWN OF DEATH
<u>Baltimore</u> | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<u>SO G H</u> | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<u>Retired</u> | 12b. KIND OF BUSINESS OR INDUSTRY
<u>Southern Galvanized</u> | |
| 13a. STATE
<u>MD</u> | | | 13b. COUNTY
<u>Baltimore</u> | 13c. CITY OR TOWN
<u>Baltimore</u> | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST <u>William</u> MIDDLE <u>W</u> LAST <u>Clinton</u> | | | 15. MOTHER'S MAIDEN NAME
FIRST <u>Anna</u> MIDDLE <u></u> LAST <u>Hitchcock</u> | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<u>no</u> | | 16b. SOCIAL SECURITY NO.
<u>194161530</u> | | 17. INFORMANT
<u>Betty Raines</u> ADDRESS <u>Balto. 21224</u>
<u>902 S. Highland Ave.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest.</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Pulmonary Edema</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Ascites, polypneumonia, CHF, ARF</u> | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR <u></u> A.M. MONTH <u></u> DAY <u></u> YEAR <u>19</u>
<u>P.M.</u> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, EARM, ETC.) | | 21f. LOCATION
STREET <u></u> CITY OR TOWN <u></u> COUNTY <u></u> STATE <u></u> | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/06</u> , 19 <u>86</u> , to <u>12/15</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>12/15</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>Michael D. Jones, MD</u> | | | | 22c. DATE SIGNED
<u>12/15/86</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>OH</u> | | | | 22e. ADDRESS
<u>3001 St. Haveren S.I.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<u>Burial</u> | | 23b. DATE
<u>12/19/86</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Cedar Hill Cemetery</u> | |
| 23d. LOCATION
CITY OR TOWN <u>Baltimore</u> COUNTY <u>AA</u> STATE <u>Co., Md.</u> | | 24. FUNERAL DIRECTOR
NAME <u>237 E. Patapsco Ave.</u>
<u>McCully Funeral Homes Balto. Md. 21225</u> | | | |
| 25a. DATE REC'D. BY REGISTRAR
<u>DEC 17 1986</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Julia D. [Signature]</u> | | | |

MEDICAL CERTIFICATION

99

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this certificate to the State Department of Health and Mental Hygiene prior to burial, cremation or other final disposition. Pages 1 and 2 should be filed with the State Department of Health and Mental Hygiene. A medical examiner must be notified at once if item 18 shows any injury, or other traumatic cause of death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause of death, a medical examiner must be notified at once.

BP

051261 1001 10 00

1001

051261 1001 10 00

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 3 4 0 0 1

1 - FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|--|---|---|---|--|
| 1. DECEASED NAME
FIRST MIDDLE LAST
LEROY ALBERT LONESOME, SR. | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 18 86 | | 2b. HOUR
11:50 PM |
| 3. SEX
MALE | 4. RACE
BLACK | 5. DATE OF BIRTH
MONTH DAY YEAR
1 25 15 | 6. AGE
(IN YEARS LAST BIRTHDAY)
71 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTO CITY MD. | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
4305 Miami Place | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Custodian | 12b. KIND OF BUSINESS OR INDUSTRY
Soc. Sec. Adm. | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | 13b. COUNTY
Baltimore | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Jesse Lonesome | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Dorsey | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WW II 213-12-4500 | 17. INFORMANT
Mrs. Baltimore, Maryland
Winifred Lonesome 4305 Miami Place 21207 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) _____
DUE TO, OR AS A CONSEQUENCE OF (b) ADENOCARCINOMA OF COLON
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Approximate interval between onset and death: 3 yrs. | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on 12/17 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Dorothy Snow | | DEGREE
M.D. | | 22c. DATE SIGNED
12/19/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DOROTHY SNOW | | 22e. ADDRESS
3900 Loch Raven Blvd BALTO, MD 21218 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Entombment | | 23b. DATE
12/23/1986 | 23c. NAME OF CEMETERY OR CREMATORY
Arbutus Memorial Park | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Maryland |
| 24. FUNERAL DIRECTOR'S NAME
NUTTER & SONS FUNERAL HOME, INC. | | | 25a. DATE REC'D. BY REGISTRAR
DEC 24 1986 | | |
| 25b. REGISTRAR'S SIGNATURE
[Signature] | | | | | |

02954-1

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then place in the removal carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | | | 2b. HOUR | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 3. SEX | | | | 4. RACE | | | |
| Ashley | | female | | | | white | | | |
| 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | | 7. IF UNDER 1 YEAR | | | |
| 12 19 86 | | 12 30 86 | | | | 11 | | | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | 10. CITY OR TOWN OF DEATH | | | |
| MD | | BALTO CITY | | | | BALTO | | | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Francis Scott Ken Med Ctr. | | N/A | | | | N/A | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. INSIDE CITY LIMITS? | | | | 13c. STREET ADDRESS / ZIP CODE | | | |
| 13a. STATE | | 13b. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 13c. 864 Birch Trail 21032 | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | | |
| 14. FIRST MIDDLE LAST | | 15. FIRST MIDDLE LAST | | | | 16a. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> (IF YES, GIVE WAR OR DATES) | | | |
| Richard Long | | Victoria Long | | | | N/A | | | |
| 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | |
| N/A | | Richard D. Long | | | | PART I. DEATH WAS CAUSED BY: | | | |
| | | 864 Birch Trail Md. | | | | IMMEDIATE CAUSE (a) Suspected septic shock | | | |
| | | | | | | (b) Respiratory failure | | | |
| | | | | | | (c) | | | |
| | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| | | | | | | 24 hours | | | |
| | | | | | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (a) | | | |
| | | | | | | Severe pulmonary interstitial emphysema / Acute renal failure | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | | |
| | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | | | |
| | | P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | | STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE | | | | 22c. DATE SIGNED | | | |
| | | Trixia Gamella | | | | 14/30/86 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | |
| TRIXIA Gamella | | FSK hospital 4940 Eastern Ave | | | | Burial | | | |
| 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION | | | |
| 1/1/86 | | Sharon Mem. Park | | | | Charlotte | | | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | |
| NAME | | ADDRESS | | | | | | | |
| Hardesty Funeral Home | | Annapolis, Md. | | | | JAN 8 1987 | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "N/A", it states any injury, or other traumatic event, the medical examiner may not be required to sign.

RELEASED NON-MED BY DR. SMYTH PER MR. RICHARDSON

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|--|--|--|---|--|--|--|
| 1- FOR STATE REGISTRAR | | REG. NO. 8634667 | | DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
CHRISTOPHER Everette LONG | | 2a DATE OF DEATH MONTH DAY YEAR
DECEMBER 27, 1986 | | 2b HOUR
3:10P M | |
| 3 SEX
Male | | 4 RACE
White | | 5 DATE OF BIRTH MONTH DAY YEAR
12-19-86 | | 6 AGE (IN YEARS LAST BIRTHDAY)
YRS. 8 | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b CITIZEN OF WHAT COUNTRY?
USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | |
| 10 CITY OR TOWN OF DEATH
BALTIMORE | | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE JOHNS HOPKINS HOSPITAL | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
N/A | | 12b KIND OF BUSINESS OR INDUSTRY
N/A | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a STATE Md. 13b COUNTY AACo. 13c CITY OR TOWN Crownsville | | 13d INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e STREET ADDRESS / ZIP CODE
864 Birch Trail 21032 | | | | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST
Richard David Long | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Victoria Sullivan | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
NO | | 16b SOCIAL SECURITY NO.
N/A | | 17 INFORMANT ADDRESS
Richard D. Long Same as 13 | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hemorrhagic Pulmonary Edema
DUE TO, OR AS A CONSEQUENCE OF (b) Septic Shock
DUE TO, OR AS A CONSEQUENCE OF (c) Perforated Abdominal Viscus | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
30 min
36 hrs
Unknown | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Prematurity | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | |
| 21d INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from Dec 27 1986 to Dec 27 1986, that (I) (we) last saw the deceased alive on Dec 27 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b SIGNATURE
L.R. Scherer MD | | | | DEGREE | | 22c DATE SIGNED
12/27/86 | | 22d ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | |
| 22e ADDRESS
L.R. Scherer MD | | | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b DATE
1-1-87 | | 23c NAME OF CEMETERY OR CREMATORY
Sharon Mem. Park | | 23d LOCATION CITY OR TOWN COUNTY STATE
Charlotte N.C. | | | |
| 24 FUNERAL DIRECTOR NAME
Hardesty Funeral Home Annapolis Md. | | | | 25a DATE REC'D. BY REGISTRAR
DEC 30 1986 | | 25b REGISTRAR'S SIGNATURE
Julia Anderson-Radner | | | |

[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "The" and "and" are faintly visible.]

12 FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENICILLIN IN GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. THE MEDICAL EXAMINER, ALONG WITH FORM JM 3, RETAIN PAGE 5 FOR YOUR FILES. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS TO FUNERAL DIRECTOR; PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF CRIMINAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|---------|--|---|--|---|--|--|--|---|--|---|--|-------|--|-------------|--|--|--|---|--|----------------------------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 7a. DATE KNOWN OF DEATH | | ESTIMATED | | MONTH | | DAY | | YEAR | | 7b. HOUR | | | | | | | | | | | | | |
| Harold | | | | | | Long | | 12 | | 5 | | 19 | | 86 | | | | M | | | | | | | | | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | MONTH | | DAY | | YEAR | | 7d. HOUR | | | | | | | | | | | |
| M | | B | | 3 17 83 | | 3 YRS. | | MONTHS | | DAYS | | HOURS | | MIN. | | 12 | | 5 | | 19 86 4:49P | | | | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | | | | | | | | | |
| MD | | | | USA | | | | | | | | Baltimore City MD. | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | |
| Baltimore | | | | University Hospital | | | | N/A | | | | | | | | | | | | | | | | | | | | | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | 13e. STREET ADDRESS | | | | | | | | | | | |
| 13a. STATE | | | | | | | | | | 13b. COUNTY | | | | | | | | | | 13c. CITY OR TOWN | | | | | | | | | | | |
| MD | | | | | | | | | | | | | | | | | | | | BALTO. | | | | | | | | | | | |
| 14. FATHER'S NAME | | | | | | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | | | | | | |
| HAROLD | | | | | | | | | | SHARON | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | | | | | | | | 16b. SOCIAL SECURITY NO. | | | | | | | | | | 17. INFORMANT ADDRESS | | | | | | | | | | | |
| NO | | | | | | | | | | N/A | | | | | | | | | | HAROLD A. LONG 1173 E. NORTHERN PK | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Head trauma | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (b) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | | | | | 20. AUTOPSY? | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | | | 21b. TIME OF INJURY | | | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | | | | | | | |
| | | | | | | 4:20 P.M. 12 5 19 86 | | | | | | Pool table fell on subject | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | | | 21f. LOCATION | | | | | | | | | | | | | | | | | | | |
| | | | | | | rec. center | | | | | | 1201 Pennsylvania Ave, Balto. MD. | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | | | TITLE (SPECIFY) | | | | | | | | | | DATE SIGNED | | | | | | | | | | | | | | | |
| Margarita A. Korell | | | | | | Assistant | | | | | | | | | | 12/6/86 | | | | | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | | | ADDRESS | | | | | | | | | | | | | | | | | | | | | | | | | |
| Margarita A. Korell, M.D. | | | | | | 111 Penn St. Balto.MD. | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | | | 23b. DATE | | | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | | 23d. LOCATION | | | | | | | | | | | | | |
| BURIAL | | | | | | 12-11-86 | | | | | | CEDAR HILL | | | | | | ANNE ARUNDEL MD | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME | | | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | |
| MARCH FUNERAL HOME | | | | | | | | | | | | 1101 E. NORTH AVE. | | | | | | | | | | DEC 10 1986 | | | | | | | | | |

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(VR A15 ME (5))

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

RECEIVED NOV 11 1964



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove and retain pages 1 and 2 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|---|--|--|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Roane | | FIRST
Lottie | | LAST | | 2a. DATE OF DEATH MONTH DAY YEAR
12-18-86 | | | | 2b. HOUR
6 ¹ / ₂ AM | |
| 3. SEX
Female | | 4. RACE
B | | 5. DATE OF BIRTH
MONTH DAY YEAR
3 12 92 | | 6. AGE (IN YEARS LAST BIRTHDAY)
94 YRS | | | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Accomac, Va. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Bn Secours Hosp. Inc. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
housewife | | | | 12b. KIND OF BUSINESS OR INDUSTRY
homemaker | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MD. | | 13b. COUNTY
Balto. | | 13c. CITY OR TOWN
Balto. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
1704 W. Mosher St. 21217 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Agustus Shields | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Annie Major | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
220-14-7017 | | 17. INFORMANT
Ella Hurley | | | | ADDRESS
1805 W. Mosher St. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebrovascular Accident
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) /
(c) / | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 11a | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/13/86 to 12/18/86, that (I) (we) last saw the deceased alive on 12/18/86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Carol Kuma Choye | | | | DEGREE
M.D. | | | | 22c. DATE SIGNED
12/19/86 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
A.K. CHUPRA | | | | 22e. ADDRESS
3655 WILKENS AVE
BALTIMORE MD 21229 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
12/22/86 | | 23c. NAME OF CEMETERY OR CREMATORY
Arbutus | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto., Md. | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Leroy O. Dyett 4600 Liberty Heights | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 21 1986 | | | | 25b. REGISTRAR'S SIGNATURE
J. J. Jordan | | | |

BP

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Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be completed within 24 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|---|--|---|--|---|--|---|--|---|--|----------|--|
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
SAMUEL LUBITZ | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
12 05 86 | | | 2b. HOUR
12 15 M | | | |
| 3 SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR
12 13 26 | | 6. AGE (IN YEARS LAST BIRTHDAY)
60 59 YRS | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SINAI HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
COMPUTER PROGRAMER | | 12b. KIND OF BUSINESS OR INDUSTRY
CHIESSIE SYSTEM | | | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> XXX | | 13e. STREET ADDRESS / ZIP CODE
6822 PARSONS AVE BALTO, 21207 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
PHILIP LUBITZ | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
LENA SHER | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | | | 16b. SOCIAL SECURITY NO.
217-20-8989 | | 17. INFORMANT ADDRESS
MRS. ROSE LUBITZ
6822 PARSONS AVE. BALTO., MD 21207 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIO-RESPIRATORY ARREST
DUE TO, OR AS A CONSEQUENCE OF (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) _____
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) _____ | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET | | CITY OR TOWN | | COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/11 19 86 , to 12/5 19 86 , that (I) (we) last saw the deceased alive on 12/5 19 86 , and that in (my (our)) opinion death occurred on the date and hour and from the causes stated above, (I (we) did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Dr. Sabine Ross | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED
12/5/86 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DR. SABINE ROSS | | | | 22e. ADDRESS
SINAI HOSPITAL BALTIMORE | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
DEC:7, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY
PROGRESSIVE RUDOMER | | 23d. LOCATION CITY OR TOWN
VEREIN ROSEDALE BALTO. | | COUNTY STATE
BALTO. MD | | | |
| 24. FUNERAL DIRECTOR NAME
SOL LEVINSON & BROS., INC. | | | | 25a. DECEDENT'S SIGNATURE
Julia Anderson-Randall | | 25b. REGISTRATION SIGNATURE
DEC 9 - 1986 | | | | | |
| 6010 REISTERSTOWN RD. BALTO., MD 21215 | | | | | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove and retain pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause of death, a medical examiner must be notified and a medical certificate completed.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 3 4 0 7 1

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--------------------------------------|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
WILLIE MAE LUMPKIN | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12-21-86 | | 2b. HOUR
MIN.
4:51 P.M. | | |
| 3. SEX
FEMALE | | 4. RACE
BLACK | | 5. DATE OF BIRTH
MONTH DAY YEAR
04 10 12 | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS.
74 | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
S. CAROLINA | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD | |
| 10. CITY OR TOWN OF DEATH
BALTO. CITY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
BONSECOURS HOSP. 2000 W. BALTO ST | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| 13a. STATE
MD | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
JAKE LUMPKIN | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
SARAH WOODS | | 13e. STREET ADDRESS / ZIP CODE
714 N. GILMORE ST 21217 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
214-58-6736 | | 17. INFORMANT
ADDRESS
DAISY MOORE 714 N. GILMORE ST | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Arrest
DUE TO, OR AS A CONSEQUENCE OF (b) Probable Acute Myocardial Infarction
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c) ASCVD | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
MIN.
HRS
YRS |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
None | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I (this hospital) attended the deceased from 1-4, 1984 , to 12-21, 1986 , that I (we) last saw the deceased alive on 12-21, 1986 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I (we) did (did not) view the body after death.) | | | | | | | |
| 22b. SIGNATURE
William R. Law | | | | DEGREE
MD | | 22c. DATE SIGNED
12-22-86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
WILLIAM R. LAW MD | | | | 22e. ADDRESS
BONSECOURS HOSPITAL 2000 W. BALTIMORE ST BALTO. MD 21233 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
12/25/86 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Anne Arundel Co., Md. | |
| 24. FUNERAL DIRECTOR
NAME C March F/H West ADDRESS 4300 Wabash Ave. | | | | 25a. DATE REC'D BY REGISTRAR
DEC 24 1986 | | 25b. REGISTRAR'S SIGNATURE
Julia Anderson-Randall | |

0133 60 0830

202 CO. 1111 FIELD



DEC 24 1960

027962 DEC 23 1986

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|--|--|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR Charles Henry Lutsche CERTIFICATE OF DEATH REG. NO. 8 0 3 4 0 1 2 | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) Charles Henry Lutsche | | | | | | 2a. DATE OF DEATH
MONTH 12 DAY 15 YEAR 86 | | 2b. HOUR
11:05 AM | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH 10 DAY 21 YEAR 12 | | 6. AGE (IN YEARS LAST BIRTHDAY)
74 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
St. Agnes Hosp. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Security Guard | | 12b. KIND OF BUSINESS OR INDUSTRY
Kennecott | |
| 13a. STATE
Maryland | | | | 13b. COUNTY
A.A. | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13e. STREET ADDRESS / ZIP CODE
449 Carvel Beach Rd 21226 | | | | 15. MOTHER'S MAIDEN NAME
FIRST Bertha MIDDLE LAST Goldstraw | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No | | | |
| 16b. SOCIAL SECURITY NO.
214-03-5371 | | | | 17. INFORMANT
Frieda I. Lutsche | | ADDRESS
Same as 13e | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) aspiration pneum.
DUE TO, OR AS A CONSEQUENCE OF:
(b) progressive motor neuron disease (bulbar palsy)
DUE TO, OR AS A CONSEQUENCE OF:
(c) Recent lacunar infarct, CVA
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12-2-86 , 19 86 , to 12-15-86 , that (I) (we) last saw the deceased alive on 12-15-86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
S. Y. WONG | | | | DEGREE
MD | | | | 22c. DATE SIGNED
12-15-86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
EDNA S Y WONG | | | | 22e. ADDRESS
87 Agnes Hosp | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
12/18/86 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cem. | | 23d. LOCATION
CITY OR TOWN Baltimore COUNTY A.A. STATE MD | | 25a. DATE REC'D. BY REGISTRAR DEC 19 1986 | |
| 24. FUNERAL DIRECTOR
George J. Gonce 4001 Ritchie Hwy Balto Md | | | | | | 25b. REGISTRAR'S SIGNATURE
John Gordon | | | |

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7026345 DEC 1986

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|---------------------------------------|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Frances C. Lutz | | | 2a. DATE OF DEATH
MONTH DAY YEAR
December 3, 1986 | | 2b. HOUR
3⁰⁵ A M | | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
4 16 11 | | 6. AGE (IN YEARS LAST BIRTHDAY)
75 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
DEATON MEDICAL CENTER | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Md. | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
- - - - - | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ella Gephardt | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
no | | | |
| 16b. SOCIAL SECURITY NO.
218-14-6417 | | 17. INFORMANT
ADDRESS
Mrs. Barbara A. Lutz 4100 N. Charles St. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) RESPIRATORY ARREST
DUE TO, OR AS A CONSEQUENCE OF (b) LUNG METASTASES
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c) METASTATIC BREAST CARCINOMA
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
10/31 19 12/3 19 | | 21g. I certify that (I) (this hospital) attended the deceased from 12/3 19 above, (I) (we) (did) (did not) view the body after death. | |
| 22a. SIGNATURE
G. A. Horner, MD | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22b. DATE SIGNED
12/3/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
G. A. Horner, MD | | 22e. ADDRESS
DEATON MEDICAL CENTER, BALTIMORE, MD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Dec. 6, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY
Oak Lawn | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Md. | |
| 24. FUNERAL DIRECTOR
NAME
Leonard J. Ruck Inc. Baltimore, Maryland | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR
DEC 5 1986 | | 25b. REGISTRAR'S SIGNATURE
Frederick P. ... | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed in 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as "Not at Work" shows any injury, or other traumatic event, the medical examiner must be notified immediately.

• **Environ**

-10-11-12-

• **1997**

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DHMH - 16 60M 7/84
(VRA 15, 4)TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove when appropriate. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 86 34674 | | | |
|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | 2a. DATE OF DEATH | | MONTH DAY YEAR | |
| FRANK | | MABRY | | 12 03 86 | | 11 35 A M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| MALE | | BLACK | | MONTH DAY YEAR | | 53 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| Storey Creek | | U.S.A. | | | | City MD | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| BALTIMORE | | PSKMC | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. CITY OR TOWN | | 13c. INSIDE CITY LIMITS? | | 13d. STREET ADDRESS / ZIP CODE | |
| Md. Balto | | Turners Station | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 210 Soller Pt. Rd. 21202 | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | |
| William | | Dolena Bonnet | | | | 224-408905 | |
| 17. INFORMANT | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | 17. INFORMANT | | 17. ADDRESS | |
| Mary Moore | | 215 Walnut Ave. 21222 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | |
| PART I. DEATH WAS CAUSED BY: | | PART I. DEATH WAS CAUSED BY: | | PART I. DEATH WAS CAUSED BY: | | PART I. DEATH WAS CAUSED BY: | |
| IMMEDIATE CAUSE (a) Cardiac Arrest | | IMMEDIATE CAUSE (a) Cardiac Arrest | | IMMEDIATE CAUSE (a) Cardiac Arrest | | IMMEDIATE CAUSE (a) Cardiac Arrest | |
| DUE TO, OR AS A CONSEQUENCE OF | | DUE TO, OR AS A CONSEQUENCE OF | | DUE TO, OR AS A CONSEQUENCE OF | | DUE TO, OR AS A CONSEQUENCE OF | |
| (b) PEPSIS and Resp. Failure | | (b) PEPSIS and Resp. Failure | | (b) PEPSIS and Resp. Failure | | (b) PEPSIS and Resp. Failure | |
| DUE TO, OR AS A CONSEQUENCE OF | | DUE TO, OR AS A CONSEQUENCE OF | | DUE TO, OR AS A CONSEQUENCE OF | | DUE TO, OR AS A CONSEQUENCE OF | |
| (c) | | (c) | | (c) | | (c) | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| | | P.M. 19 | | | | | |
| 21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/01/86 to 12/03/86, that (I) (we) last saw the deceased alive on 12/03/86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. | | 22b. SIGNATURE | | 22c. DATE SIGNED | | | |
| | | Ling Chin | | 12/03/86 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | 22f. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | |
| LING CHIN | | PSKMC | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| Burial | | 12-6-86 | | Eastview Cern. | | Balto. Md. | |
| 24. FUNERAL DIRECTOR NAME | | 24. ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Jas. A. Morton & Sons | | 1701 Laurens St. | | DEC 5 1986 | | James Davidson-Randall | |

MEDICAL CERTIFICATION

34674 68

05852 00-00



BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at the time of death.

027640 DEC 1986

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 8 6 3 4 0 7 5 | |
|---|--|--|--|---|--|---|---|--|---|--|--|
| FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | |
| 1. DECEASED NAME
(TYPE OR PRINT) MAZIE CLARISSE MACKLIN | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 14 86 | | 2b. HOUR
M
12 | | | | |
| 3. SEX
Female | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
10 6 12 | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS
70 | | IF UNDER 1 YEAR
MONTHS DAYS
0 0 | | IF UNDER 72 HRS
HOURS MIN.
0 0 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
VA. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD | | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
3321 Piedmont Ave. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MD | | 13b. COUNTY | | 13c. CITY OR TOWN
BALTO. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
3321 Piedmont Ave. 21215 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Henry Parks | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Lillie Bailey | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
217-40-1823 | | 17. INFORMANT ADDRESS
Belford Macklin 3321 Piedmont Ave. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Decompensated Dilated Cardiomyopathy
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Chronic heart failure years
DUE TO, OR AS A CONSEQUENCE OF
(c) Ventricular arrhythmia years | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/1/77 , 19 86 , to 12/12 , 19 86 , that (I) (we) last saw the deceased alive on 12/12 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Patricia Davidson MD | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | 22c. DATE SIGNED
12/15/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
PATRICIA DAVIDSON MD | | | | | 22e. ADDRESS
22 S. GREENE ST. BOX 195 BALTIMORE, MD 21201 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
12/18/86 | | 23c. NAME OF CEMETERY OR CREMATORY
Arbutus Mem. Pk. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Arbutus, Md. | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Wm C Marc F/H West | | | | | ADDRESS
4300 Wabash Ave. | | 25a. DATE REC'D. BY REGISTRAR
DEC 17 1986 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson | | |

MEDICAL CERTIFICATION

05701 14 10 50



4 11/14

12

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filed in the funeral director's office, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 86 34676 | |
|--|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
Norman Kenneth MacLeod | | | | 2a. DATE OF DEATH MONTH DAY YEAR
12 30 86 | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
December 22, 1906 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Scotland | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.
80 YRS. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
3534 E. Fairmount Avenue | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Tree Surgeon | | 12b. KIND OF BUSINESS OR INDUSTRY
Forestry | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Robert MacLeod | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Petrina Robb | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES)
1927-1932 | | 17. INFORMANT ADDRESS
Margaret E. MacLeod (same as 13e.) | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardio Pulmonary Arrest</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>G.I. Bleed -</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Pulmonary Failure -</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6/84</u> , 19 <u>84</u> , to <u>12</u> , 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>12/26</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>M. Welinsky</u> | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12/30/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
M. Welinsky | | 22e. ADDRESS
3411 Bank Street Baltimore, Maryland 21224 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | 23b. DATE
12/31/1986 | | 23c. NAME OF CEMETERY OR CREMATORY
Green Mount Crematory | |
| 24. FUNERAL DIRECTOR NAME
Walter Brooks Bradley Inc. | | ADDRESS
Balto., Md. 21222 | | 25a. DATE REC'D. BY REGISTRAR
DEC 31 1986 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
Julia Tidwell-Randall | |
| 23d. LOCATION CITY OR TOWN
Baltimore | | COUNTY
Baltimore | | STATE
Maryland | |

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 3 4 6 7 7

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | | |
|--|--|--|--|---|---|--|--|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MURRY AKA MURRAY MIDDLE LAST MACK JR. | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 12 86 | | 2b. HOUR
11:42 PM | | | | | | |
| 3. SEX
Male | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
1-30-36 | | 6. AGE (IN YEARS LAST BIRTHDAY)
50 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
South Carolina | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE CITY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNIVERSITY OF MARYLAND HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 13a. STATE
MD | | 13b. COUNTY
BALTIMORE CITY | | 13c. CITY OR TOWN
BALTIMORE | | 13e. STREET ADDRESS / ZIP CODE
2432 McCulloh St 21217 | | | | | |
| 14. FATHER'S NAME
FIRST MURRAY MIDDLE LAST MACK SR. | | | | 15. MOTHER'S MAIDEN NAME
FIRST Annie MIDDLE Lee LAST Dawson | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
579-50-9770 | | 17. INFORMANT
ADDRESS
Mrs. Betty Mack 2432 McCulloh St 21217 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) HYPOTENSION, BRADYCARDIA (PERISTEM) | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
90 min | |
| DUE TO, OR AS A CONSEQUENCE OF
(b) SEPSIS, MULTISYSTEM FAILURE | | | | | | | | | | 4 weeks | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) CECAL PERFORATION, IMMUNOSUPPRESSIVE MEDICATION | | | | | | | | | | 5 weeks | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
S/P CADAVERIC RENAL TRANSPLANT | | | | | | | | | | | |
| 19a. DATE OF OPERATION
11/8/86 | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
CECAL PERFORATION | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/8 1986, to 12/12 1986, that (I) (we) last saw the deceased alive on 12/12/86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (I) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
John A. Maw | | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
12/13/86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
John A. Maw | | | | | | 22e. ADDRESS
DEPT. SURGERY, UNIV. MD BALTIMORE | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(TYPE)
BURIAL | | | 23b. DATE
12-18-86 | | 23c. NAME OF CEMETERY OR CREMATORY
Church Cem. | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
McBee 5101 S.C. | | | |
| 24. FUNERAL DIRECTOR
NAME Joseph L. Russ 2222 W. North Ave. | | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 31 1986 | | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.

NO. 29105

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027475 DEC 17

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 3 4 6 7 8

REG. NO.

| | | | | | | | | | |
|---|--|--|--|---|--|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
SAMUEL J. MAE | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 9 86 | | | 2b. HOUR
2209M | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
2 10 18 | | 6. AGE (IN YEARS LAST BIRTHDAY)
68 YRS | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
ST. AGNES HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
GREENSKEEPER | | 12b. KIND OF BUSINESS OR INDUSTRY
Country Club | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MD | | 13b. CITY OR TOWN
BALTIMORE | | 13c. CITY OR TOWN
Catonsville | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
312 INGLESIDE AVE 21228 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Joseph Maggio | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Lydia Hardesty | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WW II | | 17. INFORMANT
Josephine Mae | | ADDRESS
Same as # 13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Ant. Myocardial Infarction
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiogenic Shock
DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Failure, Cong. heart failure
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: None | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Garag | | | DEGREE | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
12/19/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
GARAG | | | 22e. ADDRESS
St Agnes Hop. Balt MD | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
12/13/86 | | 23c. NAME OF CEMETERY OR CREMATORY
New Cathedral Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Maryland | | |
| 24. FUNERAL DIRECTOR
NAME
Lero M. & Russell C. Witzke Funeral Homes P.A.
ADDRESS
1630 Edmondson Avenue, Catonsville, MD. 21228 | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 16 1986 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

027122 DEC 5 1986

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 3 4 6 7 9

REG. NO.

| | | | | | | | | | | | |
|--|--|--|--|---|--|--|--|--|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
LINCOLN | | | 2a. DATE OF DEATH
MONTH DAY YEAR
DECEMBER 2, 1986 | | | 2b. HOUR
3:55
M | | | | | |
| 3. SEX
Male | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
4 8 08 | | 6. AGE (IN YEARS LAST BIRTHDAY)
78
YRS | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY
MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE JOHNS HOPKINS HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
Md. | | | 13b. COUNTY
Balto. | | 13c. CITY OR TOWN
Balto. | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
2039 E. Fairmount Ave. 21231 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Lincoln Magazine | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Eleanor Tidie | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Unkn. | | | 16b. SOCIAL SECURITY NO.
220-07-9559 | | 17. INFORMANT ADDRESS
Mr. Ray Williams - Same as #13 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiopulmonary Arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) SEPSIS
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 minute
72 hours | | | |
| | | | | | | | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a)
Cerebrovascular Accident | | | |
| | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/30 , 19 86 , to 12/2 , 19 86 , that (I) (we) last saw the deceased alive on 12/2/86 , 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Suzanne Koven | | | | 22c. DATE SIGNED
12/2/86 | | | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
SUZANNE KOVEN | | 22e. ADDRESS
Johns Hopkins Hospital | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Removal | | 23b. DATE
12-9-86 | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Anatomy Board | | | | 24b. ADDRESS
Balto., Md. | | 25a. DATE REC'D. BY REGISTRAR
DEC 11 1986 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Rodriguez | | | |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows evidence of only one cause of death, the medical examiner must be notified at once.

05/08/06

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the deceased certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reinsert this certificate in pages 1 and 2 and it should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

02518-1-1030

AT THE OFFICE OF THE
SHERIFF

RECEIVED
COTTON TUBES



DEC 11 1930

026487 DEC-9 1986

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | |
|---|--|---|--|---|---|---|---|--|--|---------------------------------------|------------|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST
EVELYN B. | | MIDDLE
MAIDEN | LAST | | 2a. DATE OF DEATH | | MONTH
12 | DAY
3 | YEAR
86 | 2b. HOUR
11:30 P.M. | | |
| 3. SEX
FEMALE | | 4. RACE
BLACK | | 5. DATE OF BIRTH | | MONTH
02 | | DAY
23 | YEAR
1915 | 6. AGE (IN YEARS LAST BIRTHDAY)
71 | | 7. IF UNDER 1 YEAR
MONTHS
DAYS
HOURS
MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE, | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SINAI HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
DOMESTIC | | 12b. KIND OF BUSINESS OR INDUSTRY
PVT. FAMILY | | | | | | | | |
| 13a. STATE
MARYLAND | | 13b. COUNTY | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
BALTO, MD, 21215
4013 RIDGEWOOD AVENUE | | | | | | |
| 14. FATHER'S NAME
FIRST
HARRY | | MIDDLE | | LAST
WATSON | | 15. MOTHER'S MAIDEN NAME
FIRST
MARY | | MIDDLE | | LAST
STEWART | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | (IF YES, GIVE WAR OR DATES) | | 16b. SOCIAL SECURITY NO.
219-16-7912A | | 17. INFORMANT
MR. BERNARD MAIDEN | | BALTIMORE, MD, 21216
4013 RIDGEWOOD AVENUE | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARDIO PULM ARREST</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>METASTATIC CA OF BREAST</u>
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET | | CITY OR TOWN | | COUNTY | | STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____. that (I) (we) lost saw the deceased alive on <u>12/3/86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | |
| 22b. SIGNATURE
K. Keren M.D. | | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12/3/86. | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
RON KEREN | | | 22e. ADDRESS
SINAI HOSP | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | | 23b. DATE
12/09/1986 | | 23c. NAME OF CEMETERY OR CREMATORY
GARRISON FOREST VETERANS | | 23d. LOCATION
CITY OR TOWN
BALTIMORE, MARYLAND | | | | | | | |
| 24. FUNERAL HOME OR OTHER PREPARATOR
NUTTER & SONS FUNERAL HOME, INC.
2501 GWYNNS FALLS PKWY, BALTO. MD, 21216 | | | 25a. DATE REC'D. BY REGISTRAR
DEC 8 - 1986 | | 25. REGISTRAR'S SIGNATURE
Julia Anderson-Randall | | | | | | | | | |

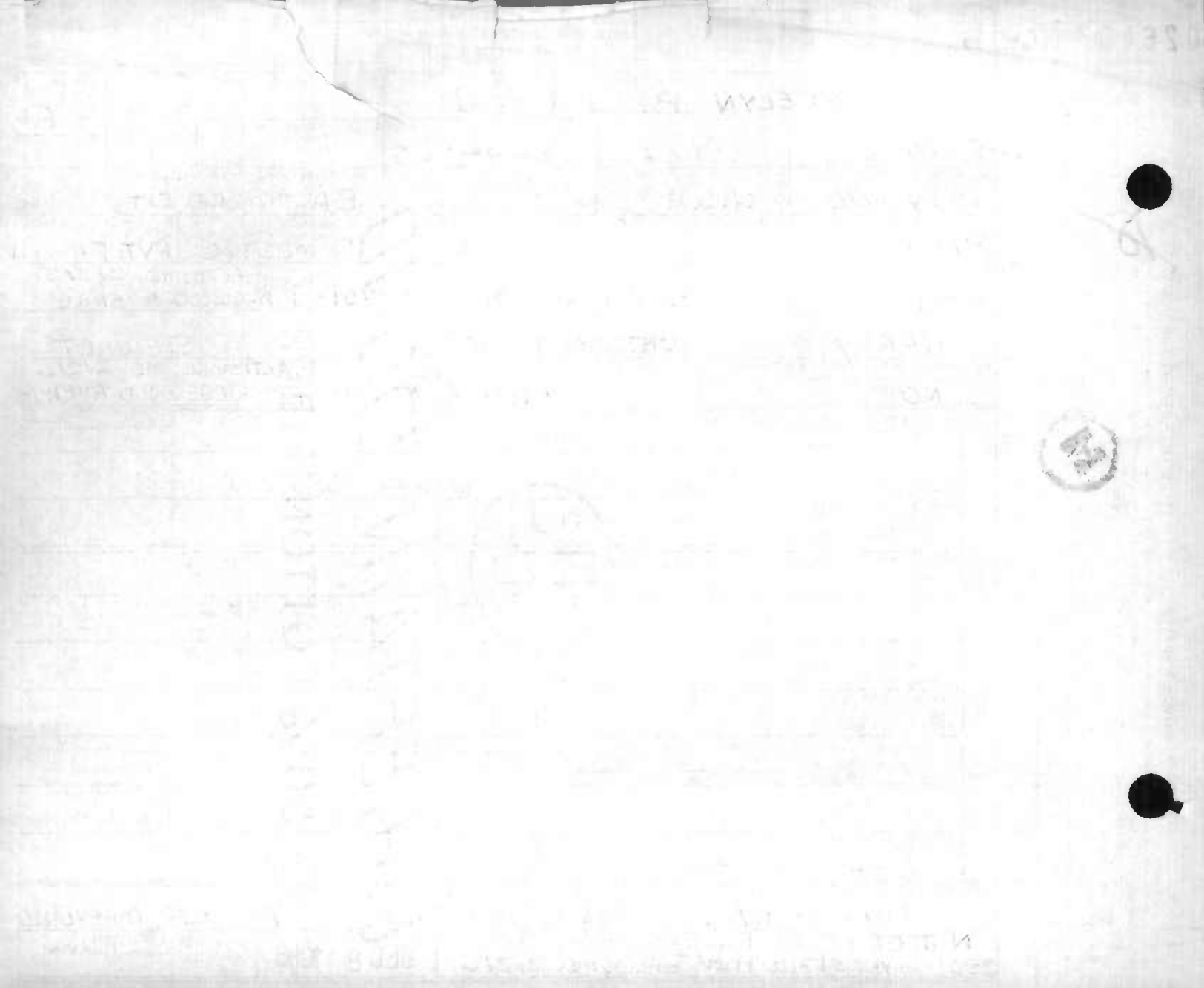
MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation or other disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



028002 DEC 23 1986

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 3 4 6 8 1

REG. NO.

| | | | | | | | | | | | | |
|---|--|---------|--|------------------|------------------------------------|---|---|---|--|------------------------|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | | 2b. HOUR | | |
| EDNA M MAIZE | | | | | | DECEMBER, 18 1986 | | | | 5:04 P | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS (LAST BIRTHDAY)) | | | | 7. IF UNDER 1 YEAR | | |
| FEMALE | | WHITE | | APRIL 22, 1915 | | 71 YRS | | | | MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | |
| Maryland | | | O-S-A | | | BALTIMORE CITY MD | | | | | | |
| 11. CITY OR TOWN OF DEATH | | | 12. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| BALTIMORE | | | THE JOHNS HOPKINS HOSPITAL | | | | | | Mso. Sec. | | JOHNS | |
| 13a. STATE | | | 13b. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? | | | 13e. STREET ADDRESS / ZIP CODE | | | |
| Maryland | | | BALTIMORE PARKVILLE | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 21234 3036 SOBEMWOOD AVE | | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | |
| CLARENCE L. LITTLE | | | Minnie B. DeBus | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT ADDRESS | | | | | | |
| NO | | | | | | FAMILY RECORDS | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST | | | | | | | | | | | 30 minutes | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | | 2 months | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | |
| (c) MIXED LYMPHOCYTIC-HISTIOCYTIC LYMPHOMA. | | | | | | | | | | | 10 years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | |
| | | | P.M. 19 | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from November 4, 1986, to December 18, 1986, that (I) (we) last saw the deceased alive on December 18, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE | | | DEGREE | | | | | | 22c. DATE SIGNED | | | |
| Robert A. Luke MD | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | | | 12/18/86 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22e. ADDRESS | | | | | | | | | |
| ROBERT A. LUKE, MD | | | JOHNS HOPKINS HOSPITAL | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | |
| BURIAL | | | 12-22-1986 | | OLD HAR. PRIM. CH. BAP. | | | BELAIR HARBOR MD | | | | |
| 24. FUNERAL DIRECTOR NAME | | | 24a. ADDRESS | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | |
| EVANS C. HARRIS | | | 8800 HARPER ROAD | | | DEC 19 1986 | | | Julia Benson-Pindone | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon pages 1, 2, and 3 and 2 and 3 and 4 and 5 and 6 and 7 and 8 and 9 and 10 and 11 and 12 and 13 and 14 and 15 and 16 and 17 and 18 and 19 and 20 and 21 and 22 and 23 and 24 and 25 and 26 and 27 and 28 and 29 and 30 and 31 and 32 and 33 and 34 and 35 and 36 and 37 and 38 and 39 and 40 and 41 and 42 and 43 and 44 and 45 and 46 and 47 and 48 and 49 and 50 and 51 and 52 and 53 and 54 and 55 and 56 and 57 and 58 and 59 and 60 and 61 and 62 and 63 and 64 and 65 and 66 and 67 and 68 and 69 and 70 and 71 and 72 and 73 and 74 and 75 and 76 and 77 and 78 and 79 and 80 and 81 and 82 and 83 and 84 and 85 and 86 and 87 and 88 and 89 and 90 and 91 and 92 and 93 and 94 and 95 and 96 and 97 and 98 and 99 and 100 and 101 and 102 and 103 and 104 and 105 and 106 and 107 and 108 and 109 and 110 and 111 and 112 and 113 and 114 and 115 and 116 and 117 and 118 and 119 and 120 and 121 and 122 and 123 and 124 and 125 and 126 and 127 and 128 and 129 and 130 and 131 and 132 and 133 and 134 and 135 and 136 and 137 and 138 and 139 and 140 and 141 and 142 and 143 and 144 and 145 and 146 and 147 and 148 and 149 and 150 and 151 and 152 and 153 and 154 and 155 and 156 and 157 and 158 and 159 and 160 and 161 and 162 and 163 and 164 and 165 and 166 and 167 and 168 and 169 and 170 and 171 and 172 and 173 and 174 and 175 and 176 and 177 and 178 and 179 and 180 and 181 and 182 and 183 and 184 and 185 and 186 and 187 and 188 and 189 and 190 and 191 and 192 and 193 and 194 and 195 and 196 and 197 and 198 and 199 and 200 and 201 and 202 and 203 and 204 and 205 and 206 and 207 and 208 and 209 and 210 and 211 and 212 and 213 and 214 and 215 and 216 and 217 and 218 and 219 and 220 and 221 and 222 and 223 and 224 and 225 and 226 and 227 and 228 and 229 and 230 and 231 and 232 and 233 and 234 and 235 and 236 and 237 and 238 and 239 and 240 and 241 and 242 and 243 and 244 and 245 and 246 and 247 and 248 and 249 and 250 and 251 and 252 and 253 and 254 and 255 and 256 and 257 and 258 and 259 and 260 and 261 and 262 and 263 and 264 and 265 and 266 and 267 and 268 and 269 and 270 and 271 and 272 and 273 and 274 and 275 and 276 and 277 and 278 and 279 and 280 and 281 and 282 and 283 and 284 and 285 and 286 and 287 and 288 and 289 and 290 and 291 and 292 and 293 and 294 and 295 and 296 and 297 and 298 and 299 and 300 and 301 and 302 and 303 and 304 and 305 and 306 and 307 and 308 and 309 and 310 and 311 and 312 and 313 and 314 and 315 and 316 and 317 and 318 and 319 and 320 and 321 and 322 and 323 and 324 and 325 and 326 and 327 and 328 and 329 and 330 and 331 and 332 and 333 and 334 and 335 and 336 and 337 and 338 and 339 and 340 and 341 and 342 and 343 and 344 and 345 and 346 and 347 and 348 and 349 and 350 and 351 and 352 and 353 and 354 and 355 and 356 and 357 and 358 and 359 and 360 and 361 and 362 and 363 and 364 and 365 and 366 and 367 and 368 and 369 and 370 and 371 and 372 and 373 and 374 and 375 and 376 and 377 and 378 and 379 and 380 and 381 and 382 and 383 and 384 and 385 and 386 and 387 and 388 and 389 and 390 and 391 and 392 and 393 and 394 and 395 and 396 and 397 and 398 and 399 and 400 and 401 and 402 and 403 and 404 and 405 and 406 and 407 and 408 and 409 and 410 and 411 and 412 and 413 and 414 and 415 and 416 and 417 and 418 and 419 and 420 and 421 and 422 and 423 and 424 and 425 and 426 and 427 and 428 and 429 and 430 and 431 and 432 and 433 and 434 and 435 and 436 and 437 and 438 and 439 and 440 and 441 and 442 and 443 and 444 and 445 and 446 and 447 and 448 and 449 and 450 and 451 and 452 and 453 and 454 and 455 and 456 and 457 and 458 and 459 and 460 and 461 and 462 and 463 and 464 and 465 and 466 and 467 and 468 and 469 and 470 and 471 and 472 and 473 and 474 and 475 and 476 and 477 and 478 and 479 and 480 and 481 and 482 and 483 and 484 and 485 and 486 and 487 and 488 and 489 and 490 and 491 and 492 and 493 and 494 and 495 and 496 and 497 and 498 and 499 and 500 and 501 and 502 and 503 and 504 and 505 and 506 and 507 and 508 and 509 and 510 and 511 and 512 and 513 and 514 and 515 and 516 and 517 and 518 and 519 and 520 and 521 and 522 and 523 and 524 and 525 and 526 and 527 and 528 and 529 and 530 and 531 and 532 and 533 and 534 and 535 and 536 and 537 and 538 and 539 and 540 and 541 and 542 and 543 and 544 and 545 and 546 and 547 and 548 and 549 and 550 and 551 and 552 and 553 and 554 and 555 and 556 and 557 and 558 and 559 and 560 and 561 and 562 and 563 and 564 and 565 and 566 and 567 and 568 and 569 and 570 and 571 and 572 and 573 and 574 and 575 and 576 and 577 and 578 and 579 and 580 and 581 and 582 and 583 and 584 and 585 and 586 and 587 and 588 and 589 and 590 and 591 and 592 and 593 and 594 and 595 and 596 and 597 and 598 and 599 and 600 and 601 and 602 and 603 and 604 and 605 and 606 and 607 and 608 and 609 and 610 and 611 and 612 and 613 and 614 and 615 and 616 and 617 and 618 and 619 and 620 and 621 and 622 and 623 and 624 and 625 and 626 and 627 and 628 and 629 and 630 and 631 and 632 and 633 and 634 and 635 and 636 and 637 and 638 and 639 and 640 and 641 and 642 and 643 and 644 and 645 and 646 and 647 and 648 and 649 and 650 and 651 and 652 and 653 and 654 and 655 and 656 and 657 and 658 and 659 and 660 and 661 and 662 and 663 and 664 and 665 and 666 and 667 and 668 and 669 and 670 and 671 and 672 and 673 and 674 and 675 and 676 and 677 and 678 and 679 and 680 and 681 and 682 and 683 and 684 and 685 and 686 and 687 and 688 and 689 and 690 and 691 and 692 and 693 and 694 and 695 and 696 and 697 and 698 and 699 and 700 and 701 and 702 and 703 and 704 and 705 and 706 and 707 and 708 and 709 and 710 and 711 and 712 and 713 and 714 and 715 and 716 and 717 and 718 and 719 and 720 and 721 and 722 and 723 and 724 and 725 and 726 and 727 and 728 and 729 and 730 and 731 and 732 and 733 and 734 and 735 and 736 and 737 and 738 and 739 and 740 and 741 and 742 and 743 and 744 and 745 and 746 and 747 and 748 and 749 and 750 and 751 and 752 and 753 and 754 and 755 and 756 and 757 and 758 and 759 and 760 and 761 and 762 and 763 and 764 and 765 and 766 and 767 and 768 and 769 and 770 and 771 and 772 and 773 and 774 and 775 and 776 and 777 and 778 and 779 and 780 and 781 and 782 and 783 and 784 and 785 and 786 and 787 and 788 and 789 and 790 and 791 and 792 and 793 and 794 and 795 and 796 and 797 and 798 and 799 and 800 and 801 and 802 and 803 and 804 and 805 and 806 and 807 and 808 and 809 and 810 and 811 and 812 and 813 and 814 and 815 and 816 and 817 and 818 and 819 and 820 and 821 and 822 and 823 and 824 and 825 and 826 and 827 and 828 and 829 and 830 and 831 and 832 and 833 and 834 and 835 and 836 and 837 and 838 and 839 and 840 and 841 and 842 and 843 and 844 and 845 and 846 and 847 and 848 and 849 and 850 and 851 and 852 and 853 and 854 and 855 and 856 and 857 and 858 and 859 and 860 and 861 and 862 and 863 and 864 and 865 and 866 and 867 and 868 and 869 and 870 and 871 and 872 and 873 and 874 and 875 and 876 and 877 and 878 and 879 and 880 and 881 and 882 and 883 and 884 and 885 and 886 and 887 and 888 and 889 and 890 and 891 and 892 and 893 and 894 and 895 and 896 and 897 and 898 and 899 and 900 and 901 and 902 and 903 and 904 and 905 and 906 and 907 and 908 and 909 and 910 and 911 and 912 and 913 and 914 and 915 and 916 and 917 and 918 and 919 and 920 and 921 and 922 and 923 and 924 and 925 and 926 and 927 and 928 and 929 and 930 and 931 and 932 and 933 and 934 and 935 and 936 and 937 and 938 and 939 and 940 and 941 and 942 and 943 and 944 and 945 and 946 and 947 and 948 and 949 and 950 and 951 and 952 and 953 and 954 and 955 and 956 and 957 and 958 and 959 and 960 and 961 and 962 and 963 and 964 and 965 and 966 and 967 and 968 and 969 and 970 and 971 and 972 and 973 and 974 and 975 and 976 and 977 and 978 and 979 and 980 and 981 and 982 and 983 and 984 and 985 and 986 and 987 and 988 and 989 and 990 and 991 and 992 and 993 and 994 and 995 and 996 and 997 and 998 and 999 and 1000.

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026582 DEC 10 1986

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|--|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
Malczewski, Leon | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 1 86 | | | 2b. HOUR
10 ⁵⁵ AM | |
| 3. SEX
M | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH DAY YEAR
JULY 22, 1922 | | 6. AGE (IN YEARS LAST BIRTHDAY)
64 YRS | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD. | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTO. CITY MD. | | |
| 10. CITY OR TOWN OF DEATH
BALTO. | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
MERCY Hosp. | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
DISABLED | | 12b. KIND OF BUSINESS OR INDUSTRY
DIST. | |
| 13a. USUAL RESIDENCE (IF NOT IN SUCH FACILITY, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MD. | | | | 13b. COUNTY BALTO. | | 13c. CITY OR TOWN | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
JOHN MALCZEWSKI | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
FRANCES WEREDYCKI | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE YEAR OR DATES)
WELL 433-24-1584 | | 17. INFORMANT
ADDRESS
CECELIA SAUTMYER JAMES AS 13E | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Squamous cell carcinoma pharynx
DUE TO, OR AS A CONSEQUENCE OF
(b) Respiratory insufficiency
DUE TO, OR AS A CONSEQUENCE OF
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
Hypercalcemia, cachexia, progressive metastatic disease | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/3, 19 86, to 12/1, 19 86, that (I) (we) last saw the deceased alive on 12/1, 19 86, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Karen M. Lichtenfeld MD | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12/1/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
KAREN M. LICHTENFELD MD | | 22e. ADDRESS | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
12-4-86 | | 23c. NAME OF CEMETERY OR CREMATORY
ST. STANISLAUS CEM | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTO. MD. | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
THOMAS J. SKARDA 2829 HUDSON ST. | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 9 1986 | | 25b. REGISTRAR'S SIGNATURE | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please file one carbon copy. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked, item 18 shows only injury, or other traumatic event, the medical examiner must be notified.

050305 000130

[Faint, illegible text and markings covering the page, possibly bleed-through from the reverse side.]

027468 DEC 17 1986

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|--|--|--|---|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Marie Sloan Malone | | | 2a. DATE OF DEATH
MONTH 12 DAY 13 YEAR 86 | | | 2b. HOUR
2:30 M | | | | | |
| 3. SEX
female | | 4. RACE
white | | 5. DATE OF BIRTH
MONTH May DAY 11 YEAR 1894 | | 6. AGE (IN YEARS LAST BIRTHDAY)
92 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS | | 8. IF UNDER 24 HRS
HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
Jenkins Memorial Home
1000 S. Caton Ave. Balt; Md. 21229 | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
teacher | | 12b. KIND OF BUSINESS OR INDUSTRY
Balto. County | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
STATE Maryland COUNTY Baltimore | | | | | | 13b. CITY OR TOWN
Baltimore | | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS
1000 S. Caton Avenue 21229 | |
| 14. FATHER'S NAME
FIRST Gilbert R. MIDDLE Bucy LAST | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST Elizabeth A. MIDDLE Higgins LAST | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) no | | | | 16b. SOCIAL SECURITY NO.
 | | 17. INFORMANT
ADDRESS
Nursing Home Records | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive Heart Failure
DUE TO, OR AS A CONSEQUENCE OF
(b) ASCVD
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 DAYS
15 YRS | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):
RHEUMATOID ARTHRITIS | | | | | | | | | | | |
| 19a. DATE OF OPERATION
12-9-86 | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
 | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 2-9-81 to 12-13-86 , that the (we) last saw the deceased alive on 12-13-86 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, the (we) did not view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
John F. Hartman | | | | | | DEGREE
M.D. | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12-13-86 | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)
JOHN F. HARTMAN, M.D. | | | | | | 22c. ADDRESS
JENKINS-1000 S. CATON AVE. 21229 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | | 23b. DATE
12/18/86 | | 23c. NAME OF CEMETERY OR CREMATORY
New Cathedral Cemetery | | | | 23d. LOCATION
CITY OR TOWN Baltimore City COUNTY Maryland STATE | |
| 24. FUNERAL DIRECTOR
NAME
Ambrose Funeral Home | | | | | | ADDRESS
1328 Sulphur Spring Rd. | | 25a. DATE REC'D. BY REGISTRAR
DEC 16 1986 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Pendall | |

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and appropriately filed in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

March

March

March

January 1900
March 1900

026545 DEC-91

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|---------------------|---|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT) Dorothy (I.) Maloon | | | 2a. DATE OF DEATH
MONTH DAY YEAR Dec 6 86 | | 2b. HOUR
11:50 A.M. |
| 3. SEX
F | 4. RACE
B | 5. DATE OF BIRTH
MONTH DAY YEAR 10 30 31 | | 6. AGE (IN YEARS LAST BIRTHDAY)
55 YRS. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY) U.S. V.I. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. V.I. | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Balto. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Good Samaritan | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) UNK | |
| 13a. US. STATE
U.S. V.I. | | 13b. COUNTY
St. Thomas | | 13c. STREET ADDRESS / ZIP CODE
Annas Retreat, 99444 E-12 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST Joseph E. Sketton | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST FINA L. Hodge | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO.
580011885 | | 17. INFORMANT
ADDRESS Lisa Maloon 5111 Goodnow Rd. Apt. E | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) MI
DUE TO, OR AS A CONSEQUENCE OF (b) Gram Negative Septicemia
DUE TO, OR AS A CONSEQUENCE OF (c) CNS Vasculitis | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
20 min
8 wks
15 weeks |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Multiple strokes, Fascitis, Respiratory Arrest | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from Aug 28 19 86 to Dec 6 19 86 , that (I) (we) lost
saw the deceased alive on Dec 6 19 86 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
V Chang | | DEGREE | | 22c. DATE SIGNED
12/6/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
V Chang | | 22e. ADDRESS
Good Samaritan Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) BURIAL | | 23b. DATE
12 9 86 | | 23c. NAME OF CEMETERY OR CREMATORY
WESTERN CEMETERY | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
ST. THOMAS VIRGIN IS | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
DEC 8 1986 Julia Deiden-Randner | | | |
| 24. FUNERAL DIRECTOR
NAME
MARCH FUNERAL HOMES | | ADDRESS
1101 NORTH AVE | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove the certificate from the pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

BP

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(VRA 16, 4)

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026581 DEC 10 1986

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | |
|---|--|---|--|---|------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
MARY JANE MANCHESTER | | | 2a. DATE OF DEATH
MONTH DAY YEAR
December 6, 1986 | | 2b. HOUR
2:15 A.M. | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Nov. 22, 1884 | | |
| 6. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
England | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| 9. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Villa Saint Michael | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housekeeper | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Villa Saint Michael | | 12b. KIND OF BUSINESS OR INDUSTRY
Housekeeping | | |
| 13a. USUAL RESIDENCE
(IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MD | | 13b. COUNTY
BALTO. | | 13c. CITY OR TOWN
Balto. | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John Cassidy | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ann Jordon | | 16. STREET ADDRESS / ZIP CODE
902 Applewood Lane, 21212 | | |
| 17. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | 18b. SOCIAL SECURITY NO.
035 42 2690 | | 17. INFORMANT
ADDRESS
Judith Banker, Same | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiorespiratory Arrest.
DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:16 | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (this hospital) attended the deceased from Nov 85 to December 6, 1986 , that (we) last saw the deceased alive on November 6, 1986 , and that in (my/our) opinion death occurred on the date and hour and from the causes stated above (we) (did) did not view the body after death. | | | | | | |
| 22b. SIGNATURE
Ruben Reid | | DEGREE
M.D. | | 22c. DATE SIGNED
12-6-86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
RUBEN REIDER | | 22e. ADDRESS
7445 FURNACE BRANCH Rd | | 22f. REGISTRAR'S SIGNATURE
Julia Davidson-Randee | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | 23b. DATE
12/8/86 | | 23c. NAME OF CEMETERY OR CREMATORY
Green Mount | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Henry W. Jenkins & Sons Co.
4905 York Road Balto., MD 21212 | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto., MD | | 25a. DATE REC'D. BY REGISTRAR
DEC 9 1986 | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the doctor certify the deceased was recorded within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

050 000 1000

NOVEMBER 1941

Nov. 1, 1941

Nov. 1, 1941

Nov. 1, 1941

Nov. 1, 1941

Nov. 1, 1941

Nov. 1, 1941

Nov. 1, 1941

Nov. 1, 1941

Nov. 1, 1941



Nov. 1, 1941

Nov. 1, 1941

Nov. 1, 1941

Nov. 1, 1941

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|--|---|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
CURTIS RICHARD MANN SR. | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12/12/86 | | 2b. HOUR
0348 <small>am</small> |
| 3. SEX
MALE | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH DAY YEAR
APRIL 29, 1923 | | 6. AGE (IN YEARS LAST BIRTHDAY)
63 YRS. | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
VIRGINIA | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE CITY | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
ST. AGNES HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
SALESMAN/BUYER | | 12b. KIND OF BUSINESS OR INDUSTRY
CLOTHING |
| 13a. STATE
MARYLAND | 13b. COUNTY
BALTIMORE | 13c. CITY OR TOWN
WOODLAWN | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
RICHARD MANN | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
SADIE MITCHELL | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
Unknown | | 17. INFORMANT
ADDRESS
Jo ANN MEECE 1254 HILLTOP DRIVE ANNAPOLIS MD. 21401 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Recurrent VENTRICULAR FIBRILLATION. | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
4 |
| DUE TO, OR AS A CONSEQUENCE OF
(b) MYOCARDIAL ISCHEMIA. | | | | | Years |
| DUE TO, OR AS A CONSEQUENCE OF
(c) PULMONARY EMBOLI | | | | | 3 weeks |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
MYOCARDIAL INFARCTION | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from NOVEMBER 27 , 19 86 , to DECEMBER 11 , 19 86 , that (I) (we) lost
saw the deceased alive on DECEMBER 11 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Michael Shortall | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
12/12/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MICHAEL SHORTALL | | 22e. ADDRESS
ST. AGNES HOSPITAL 900 CATON AVE. MARYLAND 21229 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
12/15/86 | | 23c. NAME OF CEMETERY OR CREMATORY
CRESTLAWN CEMETERY | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
MARRIOTTSTVILLE HOWARD MARYLAND | | 24. FUNERAL DIRECTOR
LEROY M. & RUSSELL C. WITZKE FUNERAL HOMES
1630 EDMONDSON AVENUE CATONSVILLE MARYLAND 21228 | | | |
| 25a. DATE REC'D. BY REGISTRAR
DEC 16 1986 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | | |

DATE: 1/1/19

TIME: 10:00

BY: [illegible]

TO: [illegible]

FROM: [illegible]

SUBJECT: [illegible]

RECEIVED

026253 DEC-86

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 3 4 5 8 7

FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|--|--|---|--|---|--------------------------------|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
George Manson | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 2 86 | | | 2b. HOUR
M | | | |
| 3. SEX
Male | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
10 20 1941 | | 6. AGE (IN YEARS LAST BIRTHDAY)
45 YRS | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Va | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore city MD. | | | |
| 10. CITY OR TOWN OF DEATH
Balto. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
2809 Winchester Street | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Unemployed | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Md. | | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William Manson | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Margaret Cost | | | 13e. STREET ADDRESS / ZIP CODE
2809 Winchester Street 21216 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
214-38-9851 | | 17. INFORMANT
Margaret Manson | | ADDRESS
2809 Winchester Street | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardio-Respiratory Collapse</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertension</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 85</u> to <u>Present</u> , that (I) (we) lost saw the deceased alive on <u>Oct 4, 1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>A-I. Baykaler</u> | | | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12-4-86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
A-I. BAYKALER | | | | 22e. ADDRESS
831 Poplar Grove St. Bal. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
12/6/86 | | 23c. NAME OF CEMETERY OR CREMATORY
King Memorial Park | | 23d. LOCATION
CITY OR TOWN COUNTY
Randallstown MD | | | |
| 24. FUNERAL DIRECTOR
NAME
Wm C March F/H West | | | | ADDRESS
4300 Wabash Ave. | | 25a. DATE RECEIVED BY REGISTRAR
DEC 5 1986 | | | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE | | | |

MEDICAL CERTIFICATION

99

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, these detached portions, page 1 and 2, should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and/or advised.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 3 4 0 8 01

FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|--|---|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT) Charles Manuel | | | 2a. DATE OF DEATH MONTH DAY YEAR 12 25 86 | | 2b. HOUR 4 50 <small>PM</small> |
| 3. SEX M | 4. RACE B | 5. DATE OF BIRTH
MONTH DAY YEAR 12 14 23 | 6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Stockton, Md. | 7b. CITIZEN OF WHAT COUNTRY? U.S. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Balti. Ct. MD. | | |
| 10. CITY OR TOWN OF DEATH Balto. City | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Liberty Medical Center | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE Md. | 13b. COUNTY Balto. City | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE 2135 McCulloph St. 21217 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST John Manuel | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST Mary Cottman | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. 213-14-7189 | 17. INFORMANT ADDRESS
Ronald McWhite 2135 McCulloh St. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Cardio-pulm arrest
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) multiple myelomas, pneumonia
DUE TO, OR AS A CONSEQUENCE OF
(c) sepsis | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/14 , 19 86 , to 12/25 , 19 86 , that (I) (we) last saw the deceased alive on 12/25 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
[Signature] | | DEGREE
MD | | 22c. DATE SIGNED
[Signature] MD | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Toi Okorpehai, MD | | 22e. ADDRESS
Liberty medical center | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 12/30/86 | 23c. NAME OF CEMETERY OR CREMATORY Western Star | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto. Md. | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
C. Wainwright 2700 Edmondson | | | 25a. DATE REC'D. BY REGISTRAR DEC 29 1986 25b. REGISTRAR'S SIGNATURE
[Signature] | | |

BP

100-100000

NON-COLLISION LINE

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

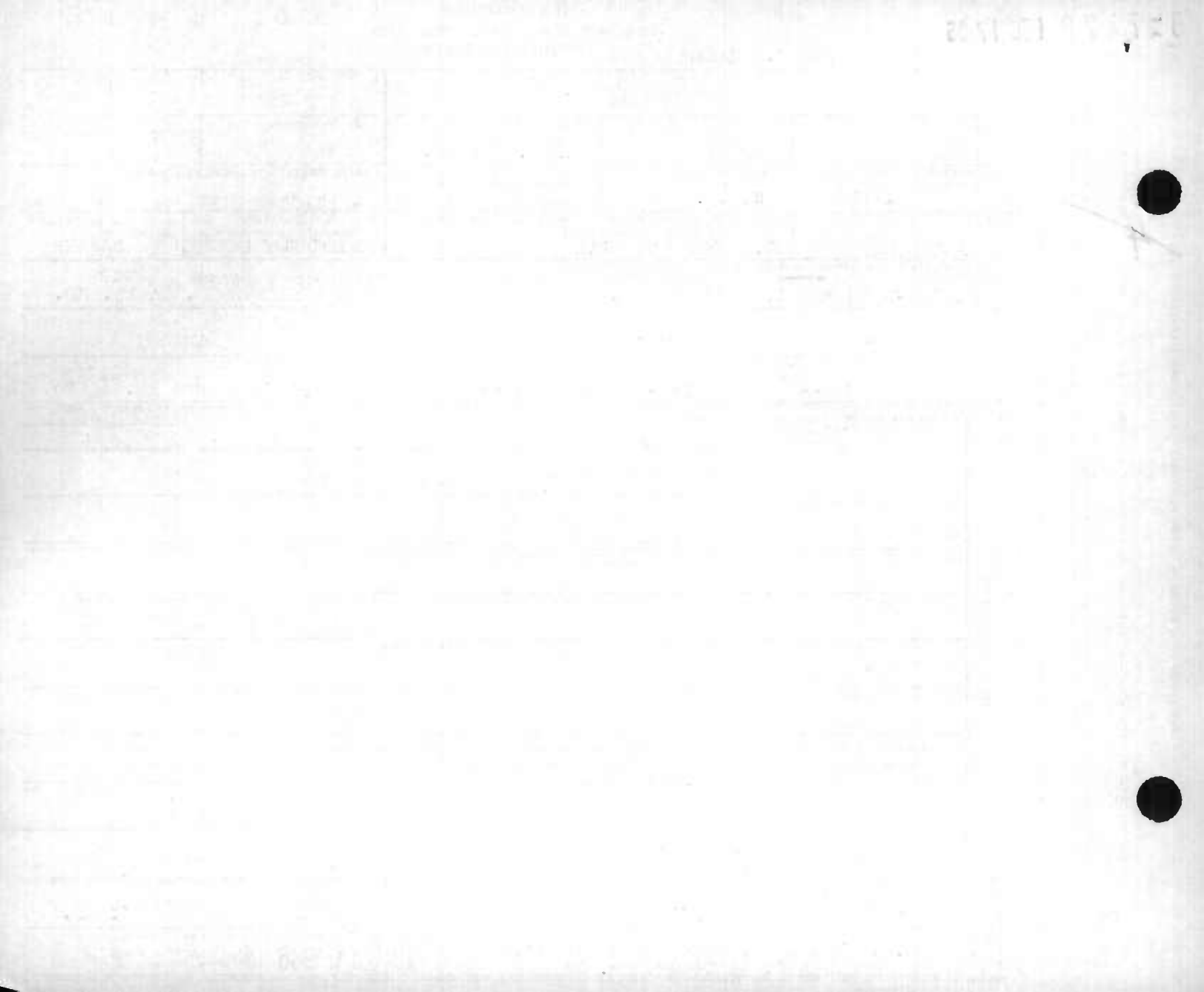
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

057478 DEC 17 1986

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 3 4 0 8 7

| | | | | | |
|---|--|--|--|--|--|
| REGISTRAR JOSEPH S. MARANTO | | | REG. NO. | | |
| 1. DECEASED NAME
(TYPE OR PRINT) <i>Joseph MORANTO</i> | | | 2a. DATE OF DEATH MONTH <i>12</i> DAY <i>13</i> YEAR <i>86</i> HOUR <i>1:34 AM</i> | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
SEPT. 19, 1890 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
ITALY | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 6. AGE (IN YEARS LAST BIRTHDAY)
96 YRS | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
ST. AGNES HOSPITAL | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 13a. STATE
MARYLAND | | 13b. CITY OR TOWN
BALTO. CITY | | 13c. STREET ADDRESS / ZIP CODE
103 WESTOWNE RD. BALTO. MD. 21229 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
CHARLES MARANTO | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ANGELA GRECO | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
RETIRED SELF EMPLOYED | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
-- | | 17. INFORMANT ADDRESS
CHARLES MARANTO 1135 WEDGEWOOD RD. BALTO. MD. 21229 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Acute Anterior Myocardial Infarction</i>
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cardiogenic shock</i>
DUE TO, OR AS A CONSEQUENCE OF (c) <i>disrhythmias</i>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>hypertension</i> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost
saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<i>Heaw</i> | | DEGREE | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>TRADEER CARL</i> | | 22e. ADDRESS
<i>St Agnes Hospital</i> | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
12/16/86 | | 23c. NAME OF CEMETERY OR CREMATORY
NEW CATHEDRAL | |
| 24. FUNERAL DIRECTOR
LEROY M. & RUSSELL C. WITZKE AND FUNERAL HOMES | | 25a. DATE REC'D. BY REGISTRAR
DEC 16 1986 | | 25b. REGISTRAR'S SIGNATURE
<i>Julia Davidson-Rubel</i> | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE BALTO CITY MD. | | | | | |



DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 3 4 6 9 0

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| FOR
REGISTRAR | | 1. DECEASED NAME
(TYPE OR PRINT) | | 2a. DATE OF DEATH | | 2b. HOUR | |
| F. C. 2196 | | JOSEPH F. MARCINETTI | | 12/18/86 | | 0645 M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| Male | | White | | Dec. 21, 1920 | | 65 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| Pennsylvania | | U.S.A. | | | | BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| BALTIMORE CITY | | ST. AGNES HOSPITAL | | Ret.- Foreman | | Carr-Lowry Ret | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | |
| MD | | Baltimore | | Lansdowne | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 13e. STREET ADDRESS / ZIP CODE | | | |
| Philip Marchinetti | | Catherine Botti | | 3125 Ryerson Cir. 21227 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| Yes | | WW 2 | | 185-16-0183 | | Ruth C. Marchinetti Same as 13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) <u>SUICIDE MECHANICAL</u> | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>DISOCIATION WITH CHARGE OF PRIST</u> | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>INFECTED WITH COMPTAILURE</u> | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (d) <u>MUTUAL REGISTRATION</u> | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (e) <u>ACUTE RENAL FAILURE</u> | | | | | | | |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>DIABETES MELLITIS, HYPERTENSION</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITIONS FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | | | |
| WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/13/86</u> to <u>12/18/86</u> , that (I) (we) lost saw the deceased alive on <u>12/17/86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | | | |
| <u>Philip Marchinetti</u> | | MD | | | | | |
| 23a. PHYSICIAN'S NAME (TYPE OR PRINT) | | 23b. ADDRESS | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | |
| Philip Marchinetti | | ST AGNES HOSP, BALI-21227 | | Meadowridge Mem. Pk. | | Elkridge Howard MD | |
| 23e. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23f. DATE | | 23g. NAME OF CEMETERY OR CREMATORY | | 23h. LOCATION | |
| Burial | | 20 Dec. 86 | | Meadowridge Mem. Pk. | | Elkridge Howard MD | |
| 24. FUNERAL DIRECTOR | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| James S. Kirkley Glen Burnie, MD 21061 | | | | DEC 19 1986 | | <u>John S. Kirkley</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, informed consent must be obtained from the next of kin.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 3 4 0 9 1

FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|--|--|---|---|---|--|--|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
MARION MARCINKOWSKI | | | 7a. DATE OF DEATH
MONTH DAY YEAR
12 8 86 | | | 7b. HOUR
7:20 A.M. | | | |
| 3. SEX
Male | | 4. RACE
Cauc. | | 5. DATE OF BIRTH
MONTH DAY YEAR
3 25 1901 | | 6. AGE (IN YEARS LAST BIRTHDAY)
85 YRS. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Poland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Mercy Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Laborer | | 12b. KIND OF BUSINESS OR INDUSTRY
GAF | | | |
| 13a. STATE
Md. | | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
xx | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Stephen Marcinkowski | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Josephine Unknwn | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO.
216-01-2088 | |
| 17. INFORMANT
Katherine Marcinkowski | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Pneumonia</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic obstructive pulmonary disease</u>
DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/3 19 86 to 12/8 19 86, that (I) (we) last saw the deceased alive on 12/8 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Michael Q. Sylva | | | | DEGREE
MD | | 22c. DATE SIGNED
12/8/86 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MICHAEL SYLVA | | | | 22e. ADDRESS
Mercy Hosp. 301 ST. PAUL PL BALT. MD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
12/11/86 | | 23c. NAME OF CEMETERY OR CREMATORY
St. Stanislaus Cem | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Md. | | | |
| 24. FUNERAL DIRECTOR
NAME
B. Dabrowski & Son 2818 E. Baltimore St. | | | | 25a. DATE REC'D BY REGISTRAR
DEC 9 1986 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please send the certificate and papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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|---|--|--|--|---|--|
| 029244 JAN - 97 | | STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | 8 6 3 4 0 9 2 | |
| 17. FOR STATE REGISTRAR | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
David J. Markoff | | 2a. DATE OF DEATH MONTH DAY YEAR
12 26 86 | | 2b. HOUR
4:15 PM | |
| 3. SEX
male | | 4. RACE
caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR
02 19 07 | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
79 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
London, Eng | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore, City MD. | | 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Snai Hospital of Baltimore | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
ATTORNEY | | 12b. KIND OF BUSINESS OR INDUSTRY
LEGAL | | | |
| 13a. STATE
MD | | 13b. COUNTY
Balt. City | | 13c. CITY OR TOWN
Baltimore | |
| 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
2428 Smith Avenue 21209 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
MAX | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
ANNIE PINCUS | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
214-34-4117 | | 17. INFORMANT ADDRESS
Stuart Markoff 2401 Oakland Ave, So Minneapolis, Minn. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute MI
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a
severe peripheral vascular disease | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION
12-9-86 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
gangrene of the right foot | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. INJURY OCCURRED
21c. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
N/A | | 21d. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | |
| 21e. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
not applicable | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE
N/A | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Dec 5, 1986 to Dec 26, 1986, that (we) last saw the deceased alive on Dec 26, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE
Mary J. Njoku MD | | 22c. DATE SIGNED
12-26-86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Mary J. Njoku MD | | 22e. ADDRESS
Snai Hospital Belvedere Greenspring 21209 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
12/31/86 | | 23c. NAME OF CEMETERY OR CREMATORY
Balt. Hebrew Cemetery | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE
Reisterstown Baltimore MD | | 24. FUNERAL DIRECTOR NAME
Hebrew Memorial F.H.-1100 Reisterstown Rd-21209 | | 25a. DATE REC'D. BY REGISTRAR
DEC 31 1986 | |
| 25b. REGISTRAR'S SIGNATURE
[Signature] | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

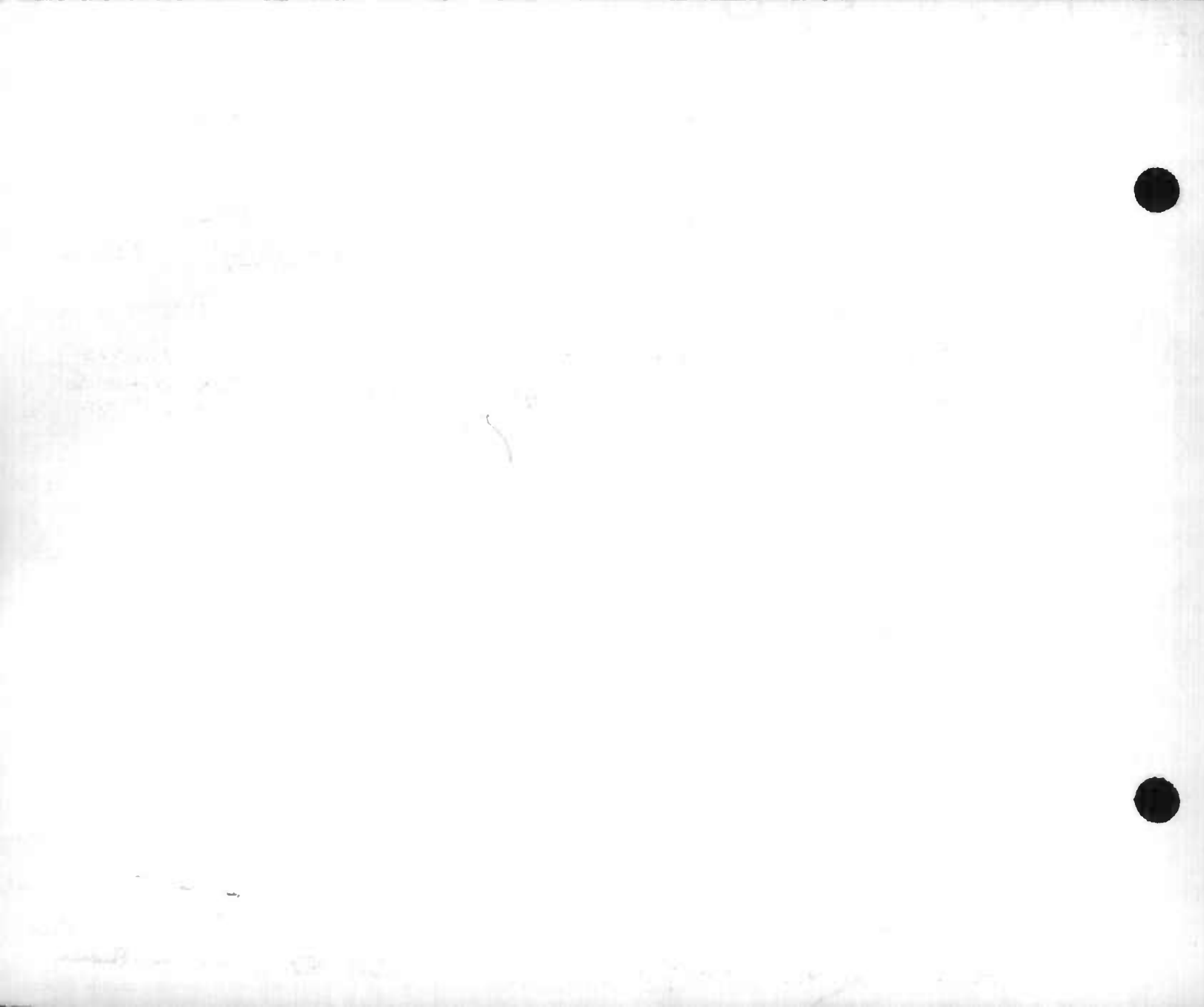
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and office.

BP

DHMH - 16 50M 4/83 (VRA 15, 4)



026764 DEC 11 1986

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|---|---|-------------------|--|--|-----------------|-----------------------------------|-----------------|----------|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | MONTH | DAY | YEAR | 2b. HOUR |
| Bertie M. Martin | | | | | 1 | 12 | 2 | 86 | 4:30 AM |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR | | IF UNDER 24 HRS | |
| Female | Black | 12 16 1906 | | | 79 YRS | MONTHS | | DAYS | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | |
| Maryland | U.S.A. | | | | Baltimore City MD. | | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Baltimore City | The Union Memorial Hospital | | | | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE | | | | |
| Maryland | | | Baltimore | YES <input type="checkbox"/> NO <input type="checkbox"/> | Formerly of 5220 York Rd 21212 | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| Henry Sutter | | Madeline Bankins | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES) | | 17. INFORMANT ADDRESS | | | | | |
| No | | 212-22-0827 | | Tamathea Douglas 3701 Twin Lakes Ct. 21207 | | | | | |

| | | |
|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY | | |
| IMMEDIATE CAUSE (a) <u>HYPOXEMIA - CARDIAC ARREST</u> | | <u>11 minutes</u> |
| DUE TO, OR AS A CONSEQUENCE OF | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | |
| (b) <u>ACUTE PULMONARY EDEMA.</u> | | <u>1 Hour</u> |
| DUE TO, OR AS A CONSEQUENCE OF | | |
| (c) <u>End Stage Cor Pulmonale and Renal Failure</u> | | |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.0

1/10 INFECTION / CLOSURE OF PLEURA

| | | | |
|---|--|--|--|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
| | | YES <input type="checkbox"/> NO <input type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9-15-86</u> , 19 <u>86</u> , to <u>12-2</u> , 19 <u>86</u> that (I) (we) lost
saw the deceased alive on <u>12-1</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
<u>P. Goldschmidt</u> | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED
12.2.86 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
P. Goldschmidt, M.D. | | 22e. ADDRESS
The Union Memorial Hospital | |

| | | | |
|---|-----------|------------------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION
CITY OR TOWN COUNTY STATE |
| Burial | 12-6-86 | New Cathedral Cemetery | Baltimore, Maryland |
| 24. FUNERAL DIRECTOR
NAME | | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
| Bailey Funeral Home 1348 N. Calhoun St. 21217 | | DEC 9 1986 | <u>John Gordon Rucker</u> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be received within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Their please remove carbonized pages. Page 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST MIDDLE LAST
LOUIS MASHBAUM | | 2a. DATE OF DEATH MONTH DAY YEAR
DECEMBER 18, 1986 | | 2b. HOUR
9:50PM
M | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR
DEC. 3, 1912 | | 6. AGE (IN YEARS LAST BIRTHDAY)
74
YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
RUSSIA | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY
MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
6600 EBERLE DR. #101 (21215) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
MAIL CARRIER. | | 12b. KIND OF BUSINESS OR INDUSTRY
U.S. POST OFFICE | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MARYLAND | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
ALEX MASHBAUM | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
ANNA KESSLER | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
YES | | | |
| 16b. SOCIAL SECURITY NO.
WWII-ARMY 215-01-5926 | | 17. INFORMANT ADDRESS
LILLIAN MASHBAUM 6600 EBERLE DR. #101 (21215) | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>acute coronary occlusion</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>hypertension</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>chronic obstructive pulmonary disease</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>chronic heart failure</u> | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>7 hours</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>Nov 26</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
JOSEPH MYEROWITZ | | | | 22c. DATE SIGNED
12/19/86 | | 22d. ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/>
PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> | |
| 22e. ADDRESS
6615 REISTERSTOWN RD. BALTO., MD. (21215) | | | | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | | |
| 23b. DATE
12/19/86 | | 23c. NAME OF CEMETERY OR CREMATORY
HEBREW YOUNG MENS. CEM. | | 23d. LOCATION CITY OR TOWN COUNTY STATE
WOODLAWN. BALTO., MD. | | 24. FUNERAL DIRECTOR
SOL LEVINSON & BROS.
6010 REISTERSTOWN RD. BALTO., MD. (21215) | |
| 25a. DATE REC'D. BY REGISTRAR
DEC 30 1986 | | | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified above.

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
RUTH H. MASSEY | | | 2a. DATE OF DEATH
MONTH DAY YEAR
MONDAY, DEC 29, 1986 | | 2b. HOUR
2:22PM |
| 3. SEX
FEMALE | 4. RACE
BLACK | 5. DATE OF BIRTH
MONTH DAY YEAR
NOV. 8 1930 | | 6. AGE (IN YEARS (LAST BIRTHDAY))
56 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?
US of A | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
3326 W. GARRISON AVENUE | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
UNEMPLOYED | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
MARYLAND | | | 13b. COUNTY | 13c. CITY OR TOWN
BALTIMORE | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
JOHN O. ALLEN | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
RUTH IRENE MOULDEN | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
217 24 5673 | | 17. INFORMANT
ADDRESS
MRS. ELENORA M. ASKINS 3326 W. GARRISON AVE 21215 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic Gastric Carcinoma
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/16 , 19 86 , to 12/29 , 19 86 , that (I) (we) lost
saw the deceased alive on 12/5 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Davis M Hohn | | DEGREE
MD | | 22c. DATE SIGNED
12/31/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Davis M Hohn | | 22e. ADDRESS
5801 Loch Raven Blvd 21239 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | 23b. DATE
1/3/87 | 23c. NAME OF CEMETERY OR CREMATORY
GARRISON FOREST VET CEM | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
OWINGS MILLS (BALTO.) MD. | |
| 24. FUNERAL DIRECTOR
NAME
LEWIS T. GWYNN | | | 25a. DATE REC'D. BY REGISTRAR
DEC 31 1986 | | |
| ADDRESS
4517 PARK HEIGHTS AVENUE | | | 25b. REGISTRAR'S SIGNATURE
A. via Benson-Rudner | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical examiner, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be held in your office until after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

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70/10/1

26910 DEC 12 1986

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

| | | | | | | | | | | |
|---|--|---|---|---|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
John E. Mastel | | | 2a. DATE OF DEATH
MONTH DAY YEAR
December 9, 1986 | | 2b. HOUR
5:30P_M | | | | | |
| 1. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
March 17, 1905 | | 6. AGE (IN YEARS LAST BIRTHDAY)
81 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
South Dakota | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
City | | | MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Edgewood Nursing Home | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Ret. Beth. Steel | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
Md. | | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Towson | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
58 Acorn Circle 21204 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Unknown Mastel | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
UNKNOWN | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
263-18-0730 | | 17. INFORMANT
ADDRESS
Mrs. Cenzi T. Mastel Same as #13e | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE
DUE TO, OR AS A CONSEQUENCE OF
(b) MYOCARDIAL INFARCTION
DUE TO, OR AS A CONSEQUENCE OF
(c) CHRONIC HEART DYSFUNCTION | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
2 mos | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a
CHRONIC HEART DYSFUNCTION | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12-9 , 19 86 , to 12-9 , 19 86 , that (b) (we) last saw the deceased alive on Nov 13 , 19 86 , and that in (c) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Charles F. Hoesch | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
12/10/86 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Charles F. Hoesch MD | | | | 22e. ADDRESS
9712 Belair Rd. Fullerton, Md. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | 23b. DATE
12-10-86 | | 23c. NAME OF CEMETERY OR CREMATORY
Westview | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Maryland | | | | |
| 24. FUNERAL DIRECTOR
NAME
Leonard J. Ruck Inc. Baltimore, Maryland | | | | 25a. DATE RECEIVED BY REGISTRAR
DEC 10 1986 | | 25b. REGISTRAR'S SIGNATURE
Charles F. Hoesch | | | | |

25810 001505

December 1, 1944

Revised

1945

City

March 17, 1945

State

Year

South America

Department of State

Information

Mr. Robert C. Smith

Director

Washington

Mr.

Mr. Robert C. Smith

Mr. Robert C. Smith

Mr.



Mr. Robert C. Smith

Mr. Robert C. Smith

Mr. Robert C. Smith

Mr. Robert C. Smith

Mr. Robert C. Smith

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

| | | | | | |
|--|--|--|--|--|---|
| 1 DECEASED NAME
(TYPE OR PRINT)
BABY BOY MATTHEWS | | | 2a DATE OF DEATH
MONTH DAY YEAR
12 - 22 - 86 | | 2b HOUR
0755AM |
| 3 SEX
MALE | 4 RACE
BLACK | 5 DATE OF BIRTH
MONTH DAY YEAR
12 22 86 | | 6 AGE (IN YEARS LAST BIRTHDAY)
2 hours YRS. | IF UNDER 1 YEAR
MONTHS DAYS
2 |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
BALTIMORE | 7b CITIZEN OF WHAT COUNTRY?
U.S. | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
BALT. CITY. MD. | |
| 10 CITY OR TOWN OF DEATH
BALTIMORE | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Maryland General | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
— | 12b KIND OF BUSINESS OR INDUSTRY
— | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a STATE
Md. | | | 13b COUNTY
BALTO | 13c CITY OR TOWN
BALTO | 13d INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
VIRGIL MATTHEWS | | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
LESLIE MATTHEWS | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
— | | 16b SOCIAL SECURITY NO.
— | | 17 INFORMANT
ADDRESS
Medical Records Dept
Md Gen'l Hosp - 827 Linden Ave. 2/20/87 | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIAC-RESPIRATORY FAILURE
DUE TO, OR AS A CONSEQUENCE OF
(b) HYALINE MEMBRANE DISEASE
DUE TO, OR AS A CONSEQUENCE OF
(c) IMMATURITY
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY
(AT HOME STREET FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a I certify that (I) (this hospital) attended the deceased from 12-22-86, 1986, to 12-22-86, 1986, that (I) (we) last saw the deceased alive on 12-22-86, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b SIGNATURE
A Macaraeg, M.D. | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c DATE SIGNED
12-22-86 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)
Art Macaraeg, M.D. | | 22e ADDRESS
c/o Maryland General Hospital | | | |
| 23a BURIAL, CREMATION, REMOVAL
(SPECIFY)
Removal | 23b DATE
12-25-86 | 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION
CITY OR TOWN COUNTY STATE | |
| 24 FUNERAL DIRECTOR
NAME
Removal/ Anatomy Board | | ADDRESS
Balto., Md. | | 25a DATE REC'D BY REGISTRAR
JAN 08 1987 | |
| | | 25b REGISTRAR'S SIGNATURE
Julia Anderson-Rudace | | | |

MEDICAL CERTIFICATION

35 48 35 300 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please forward this certificate, pages 1 and 2, to the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

100

100

100



100

100

100

027455

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 3 4 5 7 8

REG. NO.

1 - FOR
STATE
REGISTRAR1. DECEASED NAME
(TYPE OR PRINT)

George N. Matthews

2a. DATE OF DEATH MONTH DAY YEAR 12 13 86 2b. HOUR A. 6:00 M.

3. SEX

Male

4. RACE

White

5. DATE OF BIRTH

July 15, 1918

6. AGE (IN YEARS LAST BIRTHDAY)

68

7. UNDER 1 YEAR

MONTHS DAYS

IF UNDER 24 HRS.

HOURS MIN.

8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Maryland

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

9. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore, City

MD.

10. CITY OR TOWN OF DEATH

Balto. City

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

2912 Fleetwood Ave. 21214

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Ret. - Dist. Mgr. Newspaper

12b. KIND OF BUSINESS OR INDUSTRY

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

Maryland

13b. COUNTY

13c. CITY OR TOWN

Balto. City

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE

2912 Fleetwood Ave. 21214

14. FATHER'S NAME

Nicholas

MIDDLE

Matthews

15. MOTHER'S MAIDEN NAME

Mabel

MIDDLE

Medford

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)

Yes

WW II

16b. SOCIAL SECURITY NO.

215-14-9343

17. INFORMANT

ADDRESS

20904

Mr. Anthony G. Matthews - 2409 Hidden Valley, La

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Metastatic Carcinoma from

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

lung primary

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

14 MONTHS

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION

10/21/85

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR

P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22. I certify that (I) (this hospital) attended the deceased from OCTOBER 19 85 to DECEMBER 19 86, that (I) (we) last saw the deceased alive on OCT. 28 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

Lope T. Villanueva, M.D.

DEGREE

ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED

12/15/86

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

Lope T. Villanueva, M.D.

22e. ADDRESS

120 Sister Pierre Dr. Suite 103

7600 Asler Dr. 21204

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b. DATE

12-15-86

23c. NAME OF CEMETERY OR CREMATORY

Holy Redeemer

23d. LOCATION

CITY OR TOWN

Baltimore, Maryland

COUNTY

STATE

24. FUNERAL DIRECTOR

Leonard J. Ruck, Inc.

ADDRESS

5305 Harford Rd.

25a. DATE REC'D. BY REGISTRAR

DEC 16 1986

25b. REGISTRAR'S SIGNATURE

Julia Swanson-Pandey

MEDICAL CERTIFICATION

29

BP

**DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO.

FOR
STATE
REGISTRAR

| | | | | |
|---|----------------------------|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Milburn L. Matthews | | 2a. DATE KNOWN OF DEATH
ESTIMATED
12-28 1986 | | 2b. HOUR
M |
| 3. SEX
Male | 4. RACE
Black | 5. DATE OF BIRTH
MONTH DAY YEAR
2 18 34 | 6. AGE (IN YEARS LAST BIRTHDAY)
52 YRS. | 7. IF UNDER 1 YR
MONTHS DAYS
0 0 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Balto. Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 10. CITY OR TOWN OF DEATH
Balto. Md | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
2917 Chelsea Terrace | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Starter Co. Bus Chip |
| 13a. STATE
Md. | | 13b. COUNTY
Baltimore | | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Milburn Matthews | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Carrington | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
217-24-3675 | | 17. INFORMANT
ADDRESS
Mary Bruce 2121 Windsor Garden |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hypertensive Cardiovascular Disease
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from <u>Natural cause</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | |
| ACTUAL SIGNATURE
<i>Dennis F. Smyth</i> | | TITLE (SPECIFY)
Assistant | | DATE SIGNED
12-31-86 |
| EXAMINER'S NAME (TYPE OR PRINT)
Dennis F. Smyth, M.D. | | ADDRESS
111 Penn St., Balto., Md. 21201 | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | 23b. DATE
1-2-87 | 23c. NAME OF CEMETERY OR CREMATORY
Garrison Forrest | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Maryland | |
| 24. FUNERAL DIRECTOR
NAME
Jas. A. Morton Sons | | ADDRESS
1701 Laurens St. | | 25a. DATE REC'D. BY REGISTRAR
DEC 31 1986 |
| | | | | 25b. REGISTRAR'S SIGNATURE
<i>Lia Davidson-Randall</i> |

MEDICAL CERTIFICATION

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
15M 7/77

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

028986
1/5/87

11/2/87
12/2/87

Item # 8, Film G 623, 1/16/87 C.W.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|--|---|--|---|---|
| 1. DECEASED NAME
(LAST, FIRST, MIDDLE)
LESLIE MAXWELL | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 26 86 | | 2b. HOUR
11:25 AM | |
| 3. SEX
Male | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
5 12 43 | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
43 YRS | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | 8. IF UNDER 23 HRS
HOURS MIN. | |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
ST. Thomas Vir. Is. | | 10. CITIZEN OF WHAT COUNTRY?
USA | | 11. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | |
| 12. CITY OR TOWN OF DEATH
Randallstown | | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Baltimore County Gen Hospital | | 14. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore RANDALLS TOWNSHIP MD | |
| 15. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
15a. STATE MD 15b. COUNTY Balt 15c. CITY OR TOWN Baltimore | | 16. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 17. STREET ADDRESS / ZIP CODE
6052 Marquett Rd 21206 | |
| 18. FATHER'S NAME
FIRST MIDDLE LAST
Lestie Maxwell | | 19. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mavis Phipps | | 20. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) yes (IF YES, GIVE WAR OR DATES) | |
| 21. SOCIAL SECURITY NO.
256-70-3951 | | 22. INFORMANT
Sharon Mack | | 23. ADDRESS
Maxwell-6052 Marquett Rd | |
| 24. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) INTRA CEREBRAL HEMORRHAGE
DUE TO, OR AS A CONSEQUENCE OF (b) SEVE HYPERTENSION
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | 25. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 DAYS |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____ | | | | | |
| 26a. DATE OF OPERATION | | 26b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 26c. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 27a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 27b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 27c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 28a. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 28b. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 28c. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 29. I certify that (I) (this hospital) attended the deceased from 12/21 , 19 86 , to 12/26 , 19 86 , that (I) (we) last saw the deceased alive on 12/26 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 30. SIGNATURE
A. Osei-Wusu | | 31. DEGREE
MD | | 32. DATE SIGNED
12/26/86 | |
| 33. PHYSICIAN'S NAME (TYPE OR PRINT)
A. Osei-Wusu | | 34. ADDRESS
5710 WABASH AVE, BALI. MD 21215 | | 35. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |
| 36. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 37. DATE
12/29/86 | | 38. NAME OF CEMETERY OR CREMATORY
Garrison Forest Vet | |
| 39. FUNERAL DIRECTOR
NAME
Wm. C. March F/H | | 40. ADDRESS
1101 E. North AVENUE | | 41. DATE REC'D. BY REGISTRAR
DEC 30 1986 | |
| 42. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | 43. REGISTRAR'S SIGNATURE | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

12/11/2011

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12/11/2011

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Alexander MAASS MAYER | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 26 86 | | | 2b. HOUR
1:20 PM | | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
03 23 16 | | 6. AGE (IN YEARS LAST BIRTHDAY)
70 YRS | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 9. CITIZEN OF WHAT COUNTRY?
USA | | 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 11. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | |
| 12. CITY OR TOWN OF DEATH
BALTIMORE | | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Sinai Hospital | | | | 14. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
AGENT | | 15. KIND OF BUSINESS OR INDUSTRY
INSURANCE | |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
16a. STATE MD 16b. COUNTY BALTIMORE 16c. CITY OR TOWN Baltimore | | | | 17. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 18. STREET ADDRESS / ZIP CODE APT. 8 31 Stonehenge Circle 21208 | | | |
| 19. FATHER'S NAME
FIRST MIDDLE LAST
SIGMUND MAYER | | 20. MOTHER'S MAIDEN NAME
FIRST MIDDLE
ALMA MAASS | | | | | | | |
| 21. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | 22. SOCIAL SECURITY NO.
214-03-2438 | | 23. INFORMANT MRS. BEATRICE MAYER
31 STONEHENGE CIR., APT. 8 #21208 | | | | | |

| | | | |
|--|--|---|--|
| 24. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST
DUE TO, OR AS A CONSEQUENCE OF
(b) Sepsis
DUE TO, OR AS A CONSEQUENCE OF
(c) Consumption of Colon. | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
|--|--|---|--|

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | | | |
| 25. DATE OF OPERATION | | 26. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 27. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 28. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 29. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 30. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 31. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 32. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 33. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 34. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 35. I certify that (I) (this hospital) attended the deceased from December 26, 19 86 to December 26, 19 86 , that (I) (we) last
saw the deceased alive on December 26, 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 36. SIGNATURE
Robert K. Ruby | | 37. DEGREE
MD | | 38. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 39. DATE SIGNED
12-26-86 | |
| 40. PHYSICIAN'S NAME (TYPE OR PRINT)
Robert K. Ruby | | 41. ADDRESS
Sinai Hospital | | | | | |

| | | | | | | | |
|--|--|-----------------------------|--|---|--|--|--|
| 42. BURIAL, CREMATION, REMOVAL
(SPECIFY) BURIAL | | 43. DATE
12-28-86 | | 44. NAME OF CEMETERY OR CREMATORY
old HAR SINAI | | 45. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE MD | |
| 46. FUNERAL DIRECTOR
NAME SOL LEVINSON & BROS., INC.
ADDRESS 6010 REISTERSTOWN RD., BALTO., MD 21215 | | | | 47. DATE REC'D. BY REGISTRAR
JAN 6 1987 | | 48. REGISTRAR'S SIGNATURE
Julia Gordon-Randall | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

024310 NOV 18 1986

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | |
|---|--|--|---|--|---------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
WILLIE J. MAYFIELD | | | 2a. DATE OF DEATH
MONTH DAY YEAR
11 11 86 | | 2b. HOUR
2040 M | |
| 3. SEX
male | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
2 9 33 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Va | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 6. AGE (IN YEARS LAST BIRTHDAY)
53 YRS. | | |
| 10. CITY OR TOWN OF DEATH
Baltimore City | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
St. Agnes Hospital | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Chauffeur | | 12b. KIND OF BUSINESS OR INDUSTRY
Sunpapers | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore City | | |
| 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
5 N. Culver St | | 21229 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Willie Mayfield | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Octavia Delbridge | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
Yes | | 16b. SOCIAL SECURITY NO.
227-36-0619 | | 17. INFORMANT
ADDRESS
Sarah I. Mayfield 5 N. Culver Street | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PERITONITIS SECONDARY TO PERFORATION OF SMALL BOWEL METASTASIS
DUE TO, OR AS A CONSEQUENCE OF (b) WIDE SPREAD ADENOCARCINOMA
DUE TO, OR AS A CONSEQUENCE OF (c) PROBABLE LUNG PRIMARY PANCREAS
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
HOURS-DAYS YEAR. | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
James E Taylor | | DEGREE
M.D. | | 22c. DATE SIGNED
11/12/86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JAMES E. TAYLOR, M.D. | | 22e. ADDRESS
ST AGNES HOSPITAL | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
11/17/86 | | 23c. NAME OF CEMETERY OR CREMATORY
Crownsville Veteran Cem | | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Crownsville Md | | | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
March Funeral Home West 4300 Wabash Avenue | | | | 25a. DATE REC'D. BY REGISTRAR
NOV 4 1986 | | |
| | | | | 25b. REGISTRAR'S SIGNATURE
Julia D. [Signature] | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the physician and completely filled in by the funeral director, page 2 should be detached for use on the burial-transit permit. Then please return this report, page 1, to the State Department of Health and Mental Hygiene prior to burial, cremation or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

42

[Faint, illegible handwriting throughout the page, likely bleed-through from the reverse side.]

026368 DEC 9 1986

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Hans McCabe | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 01 86 | | 2b. HOUR
5:30pm | |
| 3. SEX
Male | | 4. RACE
Cacasion | | 5. DATE OF BIRTH
MONTH DAY YEAR
5 1 1901 | | 6. AGE (IN YEARS LAST BIRTHDAY)
85 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Scotland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore, City MD | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Union Memorial Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired Seaman | | 12b. KIND OF BUSINESS OR INDUSTRY
Paseenger Lines | |
| 13a. STATE
Md | | | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Hans McCabe | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Suzanna Smith | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
109-01-1597 | | 17. INFORMANT (spouse) ADDRESS
Stacy McCabe - Same as #13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIAC ARRHYTHMIA
DUE TO, OR AS A CONSEQUENCE OF
(b) Seizure Disorder
DUE TO, OR AS A CONSEQUENCE OF
(c) Cerebrovascular Accident | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
10 days
2 years | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a
emphysema, Colon Cancer | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from December 21 , 19 86 , to December 1 , 19 86 , that (I) (we) last saw the deceased alive on December 1 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Mark Clinton | | | | DEGREE
MD | | 22c. DATE SIGNED
12/11/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Mark Clinton, M.D. | | | | 22e. ADDRESS
Union Memorial Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Removal | | 23b. DATE
12-2-86 | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | |
| 24. FUNERAL DIRECTOR
NAME
State Anatomy Board | | | | ADDRESS
Baltimore, Md. | | | |
| 25. DATE RECEIVED BY FUNERAL DIRECTOR
DEC 04 1986 | | | | 26. REGISTRAR'S SIGNATURE
Julia Benson | | | |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: after this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 - 3 4 7 0 4

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|---|--|--|--|---|--------------------------------|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
ALBERT C. MCCAULEY | | | 2a. DATE OF DEATH
MONTH DAY YEAR
DECEMBER 28, 1986 | | | 2b. HOUR
2 45aM | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
June 6 1913 | | 6. AGE (IN YEARS LAST BIRTHDAY)
73 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
West Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Church Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Machinist | | 12b. KIND OF BUSINESS OR INDUSTRY
Cont.Can Co. | |
| 13a. STATE
Maryland | | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Melvin McCauley | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Arbquest | | | 13e. STREET ADDRESS / ZIP CODE
2112 Alma Ave. 21219 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
----- | | 17. INFORMANT
Genevieve O'Connor | | ADDRESS
11 Tinker Road 21220 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ARTERIOLOSCLEROSIS CARDIO VASCULAR DISEASE
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from DECEMBER 24 19 86 to DECEMBER 28 19 86, that (I) (we) last saw the deceased alive on DECEMBER 28 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
KARIS A. R. P. | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
KARIS A. R. P. M.D. | | | | 22e. ADDRESS
CHURCH HOSPITAL CORPORATION
101 N. BROADWAY BALTIMORE, MD 21231 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
Dec 31 1986 | | 23c. NAME OF CEMETERY OR CREMATORY
Holly Hill Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Md. | | | |
| 24. FUNERAL DIRECTOR
NAME
Lilly & Zeiler, Inc. | | | | ADDRESS
21231 1901 Eastern Ave. | | 25a. DATE REC'D. BY REGISTRAR
DEC 30 1986 | | 25b. REGISTRAR'S SIGNATURE
John Denton-Rudolph | |

MEDICAL CERTIFICATION

1

| | | | | | | | | | |
|--|--|---|--|--|---|--|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Ozie Carnell McCord | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12- 03- 86 | | | 2b. HOUR
4:30am | | | |
| 3. SEX
Male | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
09- 23- 12 | | 6. AGE (IN YEARS LAST BIRTHDAY)
74 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
South Carolina | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
1117 Woodington Road | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Laborer | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Maryland | | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Joel McCord | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Minnie Fisher | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | | |
| 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
1942-1945 | | | 17. INFORMANT
Raymond McCord | | | 17. ADDRESS
3001 Westwood Avenue | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):
PART 1. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Tracheo-esophageal Fistula
DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of esophagus
DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Obstructive Pulmonary Disease
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 wks
2 1/2 yrs | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10 | | | | | | | | | |
| 19a. DATE OF OPERATION
11/23/86 | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Tracheo-esophageal Fistula | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR AM MONTH DAY YEAR
19 86 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/2/86 to 12/3/86, that (I) (we) last saw the deceased alive on 12/2/86, and that in (my) (our) opinion death occurred on the date and hour and from the cause stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Richard A. Baum | | | | | | DEGREE | | 22c. DATE SIGNED
12/4/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Richard Baum | | | | | | 22e. ADDRESS
8023 B Ritchie Hwy Pasadena 21122 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
12-08-86 | | 23c. NAME OF CEMETERY OR CREMATORY
Garrison Forest Va. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Maryland | | |
| 24. FUNERAL DIRECTOR
NAME
Brown/Thompson F. H. | | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 10 1986 | | 25b. REGISTRAR'S SIGNATURE
Lisa Davidson | |
| ADDRESS
1913 W. Baltimore Street | | | | | | | | | |

MEDICAL CERTIFICATION

29

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1500111111

1500111111

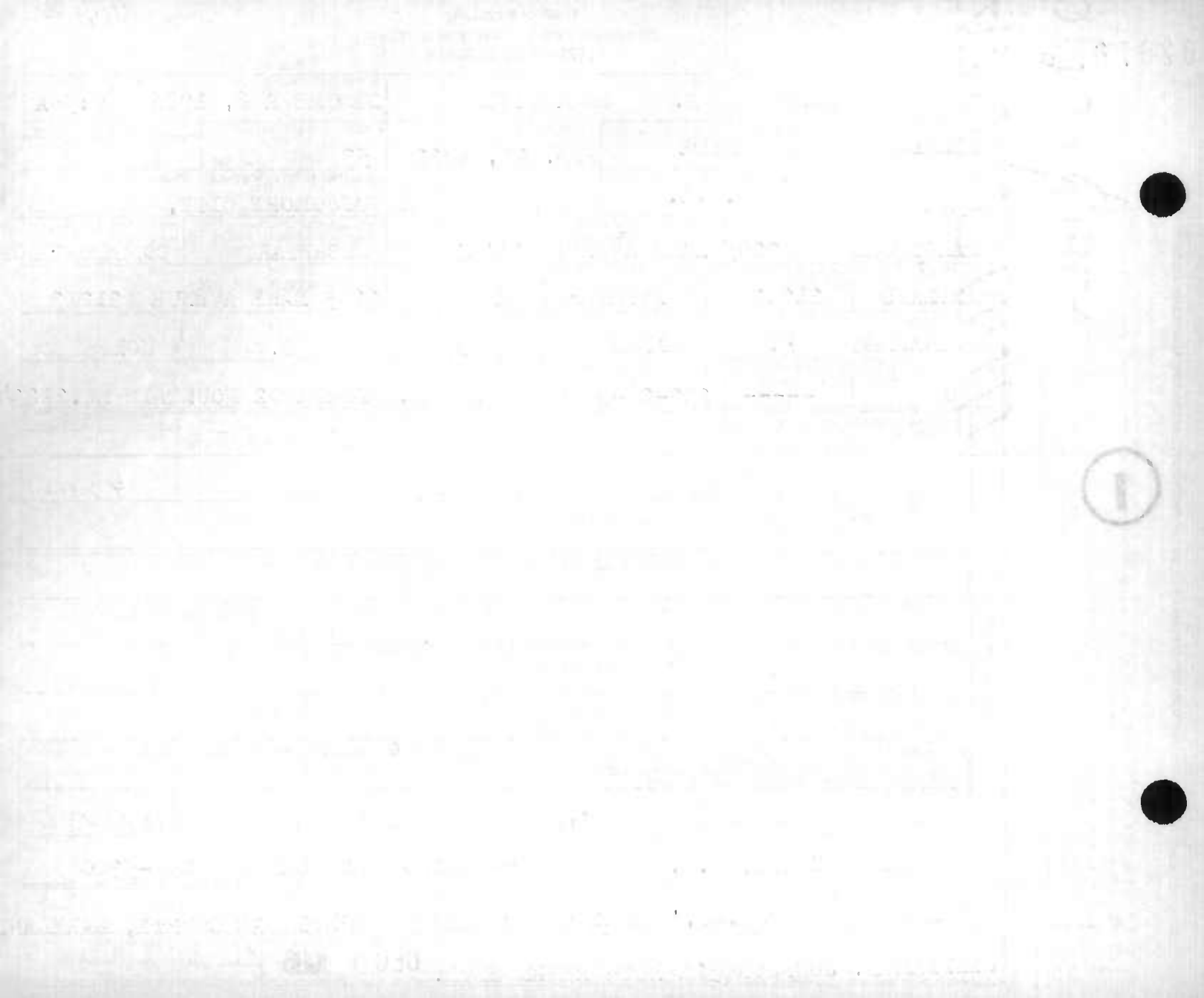
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that medical certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DHMH - 16 60M 7/84
(VRA 15, 4)

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | | | | | |
|---|--|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) CAROLYN A. McCORMICK | | | | 2a. DATE OF DEATH MONTH DAY YEAR
DECEMBER 8, 1986 | | | | 2b. HOUR
9:58A_M | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
FEB. 23, 1933 | | 6. AGE (IN YEARS LAST BIRTHDAY)
53 | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY, MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
2205 LAKE AVENUE 21213 | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
SECRETARY | | 12b. KIND OF BUSINESS OR INDUSTRY
CONSTRUCTION | |
| 13a. STATE
MARYLAND | | 13b. CITY OR TOWN
21213 | | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS / ZIP CODE
2205 LAKE AVENUE 21213 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
CHARLES E. ALLEN | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ANNA C. WOLF | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATE)
212-28-9609 | | 17. INFORMANT ADDRESS
CHARLES E. ALLEN 1902 MOUNTAIN RD. 21234 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Adenocarcinoma of Breast metastatic
DUE TO, OR AS A CONSEQUENCE OF
(b) To bone, bone marrow and brain
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4 years | | | | | | | | | |
| | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a. | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from May , 19 86 , to December 8 , 19 86 , that (I) (we) lost saw the deceased alive on December 2 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Mayer Gorbaty | | | | DEGREE
MD | | | | 22c. DATE SIGNED
12/8/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MAYER GORBATY, M.D. | | | | 22e. ADDRESS
660 KENILWORTH DRIVE 296-5300 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
BURIAL | | 23b. DATE
DEC. 10, '86 | | 23c. NAME OF CEMETERY OR CREMATORY
GARDENS OF FAITH | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE COUNTY, MARYLAND | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
WILLIAM E. JOHNSON 8521 LOCH RAVEN BLVD. | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 9 1986 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | | |



DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or entombment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | |
|--|---|---|--|---|--|
| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | |
| 1. DECEASED NAME
(TYPE OR PRINT)
EARL MILTON MCCURLEY | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 24 86 | | 2b. HOUR
6:15P. M. |
| 3. SEX
M | 4. RACE
W | 5. DATE OF BIRTH
MONTH DAY YEAR
OCT 3 1928 | 6. AGE (IN YEARS LAST BIRTHDAY)
58 YRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
St. Agnes Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Carpenter | 12b. KIND OF BUSINESS OR INDUSTRY
Construction | |
| 13a. STATE
Maryland | | 13b. COUNTY | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
2425 Christian Street 21223 |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Edward Leroy McCurley | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Marie Magdalena Scharf | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
Korea 220-22-6528 | | 17. INFORMANT
ADDRESS
Rita McCurley 2425 Christian St. 21223 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiac arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>H A C V D</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>immediate</u>
<u>25 yrs</u> | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a: | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
DEGREE
<u>Herman Baylus</u> | | | | 22c. DATE SIGNED
26 DEC 86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Herman Baylus | | | | 22e. ADDRESS
1600 Wilkens Avenue | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
12/29/86 | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park Cemetery | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Maryland | |
| 24. FUNERAL DIRECTOR
NAME
Hubbard Funeral Home, Inc. 4107 Wilkens Ave. | | | 25a. DATE REC'D. BY REGISTRAR
DEC 29 1986 | 25b. REGISTRAR'S SIGNATURE
<u>Julia Davidson-Pudell</u> | |

2012-11-08

44



027023 DEC 15 1986

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | |
| 7. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | 12 9 86 | | 2:59 P M | |
| MOSE | | MCDANIEL | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| M | | B | | MONTH DAY YEAR | | YRS MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| S. C | | USA | | | | Baltimore City MD | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| BALTIMORE | | Sinai Hospital | | Disabled | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. CITY OR TOWN | | 13c. INSIDE CITY LIMITS? | | 13d. STREET ADDRESS / ZIP CODE | |
| 13a. STATE | | 13b. COUNTY | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 21215 3525 OAKMONT AVE | |
| Md | | Baltimore | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | NO | | | |
| Johnson | | McDaniel | | | | | |
| 17. INFORMANT | | ADDRESS | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| Rosalie Gamble | | 3525 Oakmont Ave | | PART I. DEATH WAS CAUSED BY: | | | |
| | | | | IMMEDIATE CAUSE (a) Cardiac arrest? | | | |
| | | | | DUE TO, OR AS A CONSEQUENCE OF | | | |
| | | | | (b) | | | |
| | | | | DUE TO, OR AS A CONSEQUENCE OF | | | |
| | | | | (c) | | | |
| | | | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | |
| | | | | Gastric ulcer; coagulopathy 2° to liver disease; thrombocytopenia; severe nutritional depletion | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | |
| | | P.M. 19 | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | | | |
| WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | STREET CITY OR TOWN COUNTY STATE | | | |
| | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 86, to 19, that (I) (we) lost | | 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | |
| saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated | | Rick A Martinez MD | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | |
| above, (I) (we) (did) (did not) view the body after death. | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| | | RICK A MARTINEZ | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | |
| Burial | | 12/13/86 | | Eastview Cemetery | | Baltimore MD | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| March Funeral Home West 4300 Wabash Avenue | | DEC 12 1986 | | Alicia Anderson-Randall | | | |

MEDICAL CERTIFICATION

19

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | | | |
|--|--|---|---|---|--|---|--|--|--|
| 2. DECEASED NAME
(TYPE OR PRINT)
Richard McDonald | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 23 86 | | | 2b. HOUR
M | | | |
| 3. SEX
MALE | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
7 6 1933 | | 6. AGE (IN YEARS LAST BIRTHDAY)
53
YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
VA. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Balt. City | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
1720 Edmonson Ave. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
DISABLED | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
MD | | 13b. COUNTY | | 13c. CITY OR TOWN
Balt. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
4223 1720 Edmonson Ave. | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
ELLIOTT Bentley McDonald | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Annie Parker | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO.
212-30-4523 | | 17. INFORMANT
ADDRESS
Robert Sawyer 356 Jennings Rd. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic Squamous Cell Carcinoma of the Esophagus
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Dysphagia and Malnutrition | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I (this hospital) attended the deceased from November 19 86, to Nov 21 19 86, that (I (we) last saw the deceased alive on Nov 21 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
James E Kelly DO | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
James E Kelly DO | | | | 22e. ADDRESS
Balt. Maryland General Hosp 827 Linden Ave. MD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) BURIAL | | 23b. DATE
12-27-86 | | 23c. NAME OF CEMETERY OR CREMATORY
Eastview Mem | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Dundalk MD | | | |
| 24. FUNERAL DIRECTOR
NAME
JERR Miller FH 4611 Park Hgts | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 30 1986 | | 25b. REGISTRAR'S SIGNATURE
Julia Gordon-Randall | | | |

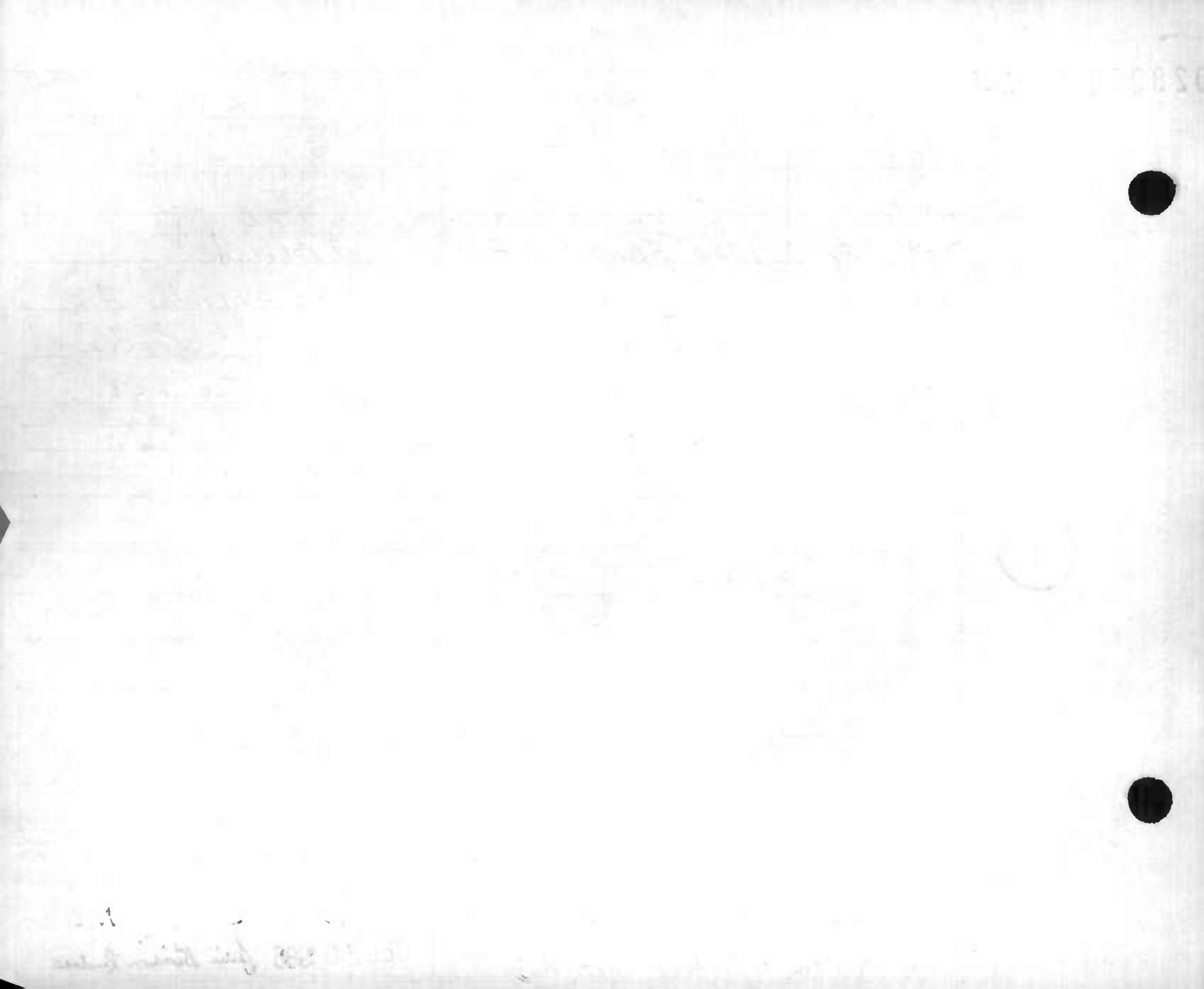
MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. It will please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use on the burial transit permit. Then please remove collectors' Pages 1 and 2 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as (1), 18 states only injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | |
|--|---|--|--------|---|--|
| 1- FOR STATE REGISTRAR | | DECEASED NAME | | 2a. DATE OF DEATH | |
| FIRST MIDDLE LAST | | MONTH DAY YEAR | | MONTH DAY YEAR HOUR | |
| RUTH ANNA McEVOY | | 12 19 86 | | 455P ^M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE | 7. IF UNDER 1 YEAR | |
| Female | White | MONTH DAY YEAR | 86 | MONTHS DAYS HOURS MIN. | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION | 12a. USUAL OCCUPATION | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Baltimore | St. Agnes Hospital | Housewife | | Home | |
| 13a. CITY OR TOWN | | 13b. STREET ADDRESS / ZIP CODE | | 13c. CITY OR TOWN | |
| Baltimore | | 5713 Edmondson Avenue | | Apt. TA 1 21228 | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | | |
| Henry Louis Marburger | | Sophie Katherine Villmar | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| No | | 213-46-4927 | | Charles P. McEvoy Jr. 258 Blakeney Road Catonsville, MD. 21228 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | |
| IMMEDIATE CAUSE (a) Left intracerebral hemorrhage | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) ASVD HTN | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) many years | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a | | | | | |
| No atrial fibrillation | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED | |
| | | HOUR A.M. MONTH DAY YEAR | | (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY | | 21f. LOCATION | |
| AT HOME <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | [AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.] | | CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/19 19 86, to 12/19 19 86, that (I) (we) last saw the deceased alive on 12/17 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | |
| Paul M. Gormley MD | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 12/19/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| Paul Gormley MD | | St. Agnes Hosp. Baltimore, MD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 12/22/86 | | Lorraine Park Cemetery | |
| | | | | CITY OR TOWN COUNTY STATE | |
| | | | | Woodlawn Maryland | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| LEROY M. & Russell C. Witzke Funeral Homes P.A. 1630 Edmondson Avenue, Catonsville, MD. 21228 | | DEC 22 1986 | | Julia D. [Signature] | |

1008



RECEIVED

1008

029249 JAN-507

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 3 4 7 1 1

REG. NO.

| | | | | | | | |
|--|---|---|--|--|-----------------------------------|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST MIDDLE LAST | | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR | |
| JOHN | | MCGHEE | | DECEMBER 25, 1986 | | 3:00 PM | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR | |
| Male | Black | MONTH DAY YEAR
12 13 1902 | | 84 YRS | | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Halifax, VA. | USA | | | BALTIMORE CITY MD | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| BALTIMORE | THE JOHNS HOPKINS HOSPITAL | | Construction | | Retired | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13d. STREET ADDRESS / ZIP CODE | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. STREET ADDRESS / ZIP CODE | |
| Md | | | | Balto. | | 2000 Odell Ave. 21231 | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | ADDRESS | | | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | 2000 Odell Ave Apt 107 | | | |
| Arthur McGhee | | Rose White | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | |
| No | | | | Cornelia McGhee | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY: | | IMMEDIATE CAUSE (a) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| | | Cardiorespiratory Arrest | | 5 min | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| | | (b) pneumonia | | 1 wk | | | |
| | | DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| | | (c) stroke | | 1 wk | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/13, 1986, to 12/25, 1986, that (I) (we) last saw the deceased alive on 12/25, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | | | |
| James Corkum | | MD | | 12/25/86 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | |
| James Corkum | | 601 N. Wolfe St, BALTO, MD, Johns Hopkins Hospital | | 21205 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIAL) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | |
| Burial | | 12-29-86 | | Md. National | | Laurel MD | |
| 24. FUNERAL DIRECTOR
NAME | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Jas. A. Maetland Sons | | 1701 Laurens | | DEC 31 1986 | | Julia Benson-Randee | |

MEDICAL CERTIFICATION

9/21/86

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed with 4 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy 1-2-1986 and be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

18/12/01
HCBLL 10MB

P 772 JP 58 1

027025 DEC 30

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 3 4 / 1 2

REG. NO.

| | | | | | | | |
|--|--|--|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Marjorie Virginia McGinn | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 9 86 | | | 2b. HOUR
11:26AM | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
12 26 30 | | 6. AGE (IN YEARS LAST BIRTHDAY)
55 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
St. Agnes Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Sales Clerk | | 12b. KIND OF BUSINESS OR INDUSTRY
Retail | |
| 13a. STATE
MD | | 13b. COUNTY
Howard | | 13c. CITY OR TOWN
Ellicott City | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
George Paul Traband | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Hilda Harden | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO | | | |
| 16b. SOCIAL SECURITY NO.
216-28-2895 | | 17. INFORMANT ADDRESS
12604 Mt Laurel Ct., 21136
Walter L. McGinn, Jr. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Myocardial Infarction
DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Artery Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) MIC Compensated Heart Failure
DUE TO, OR AS A CONSEQUENCE OF (c) MIC Compensated Heart Failure
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Coronary Artery Disease
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/7 , 19 77 , to 12/9 , 19 86 , that (I) (we) lost
saw the deceased alive on 12/2 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above (I) (we) (did, did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
John C. Healy MD | | | | DEGREE
MD | | 22c. DATE SIGNED
12/9/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
John C. Healy MD | | | | 22e. ADDRESS
1311 FRANCIS Ave - BOSTON, MA 02115 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
12/12/86 | | 23c. NAME OF CEMETERY OR CREMATORY
Woodlawn Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Woodlawn Baltimore MD | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
MacNabb Funeral Home, Catonsville, MD | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 12 1986 | | | |
| 25b. REGISTRAR'S SIGNATURE
John C. Healy | | | | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and carefully filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 show any injury, or other traumatic event, or other traumatic event, the medical examiner must be notified.

BP

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MASS: 11 8 9 31

MASS: 11 8 9 31

026854 DEC

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

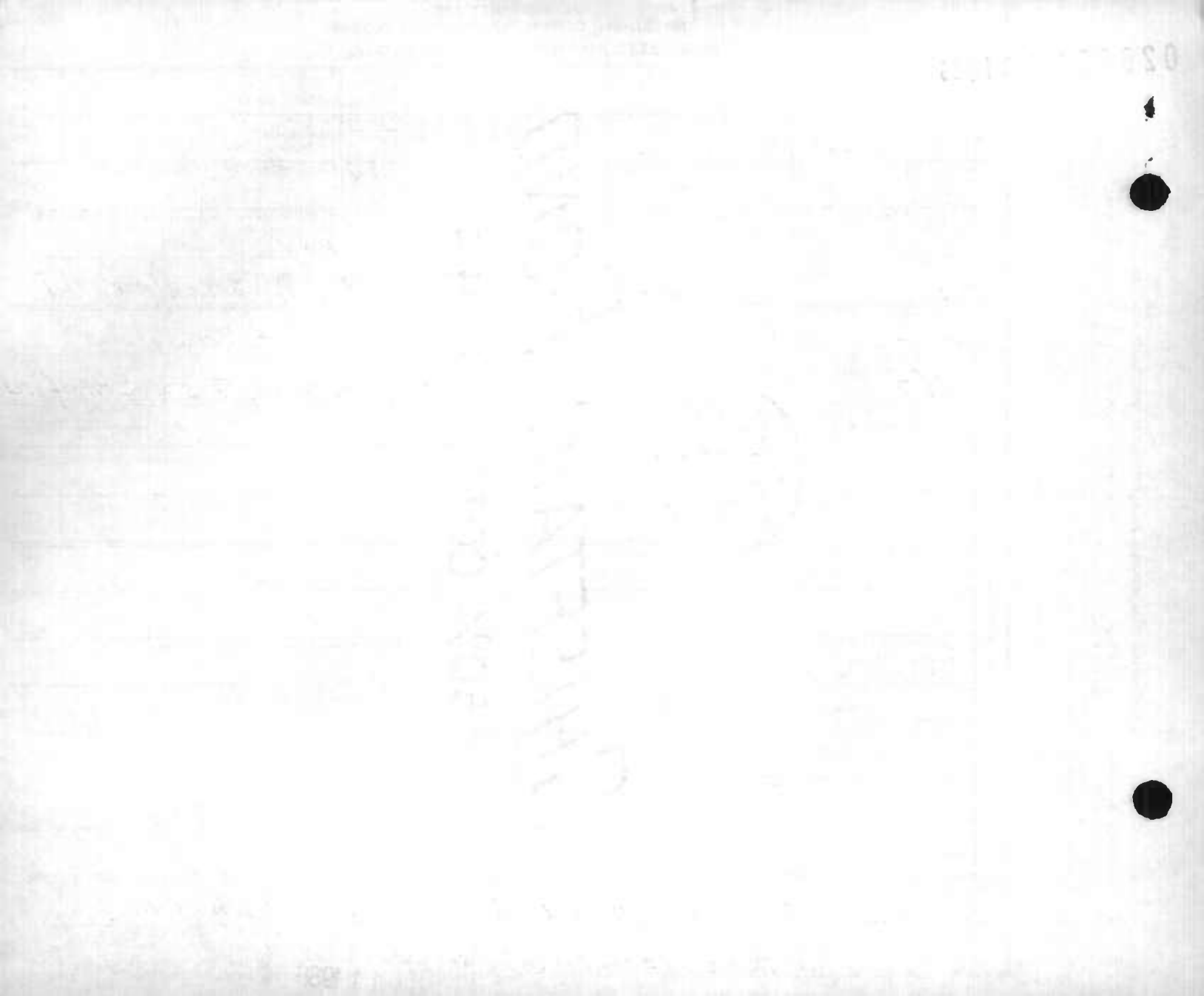
07/84
25M
 BP
DHMH - 17
(VR A15 ME (5))

 1- FOR
STATE
REGISTRAR

 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|--|---------|---|--------|--|-------------------------|---|---|---|-------|--|----------|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 2a. DATE KNOWN OF DEATH | | <input checked="" type="checkbox"/> MONTH | DAY | YEAR | 2b. HOUR | |
| Aaron McKethan | | | | | 12/ 7/ 1986 | | | | | M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | IF UNDER 1 YR. | IF UNDER 24 HRS. | 7c. DATE PRONOUNCED DEAD | | MONTH | DAY | YEAR |
| M | NEGRO | 8 10 86 | | YRS. 3 | 30 | HOURS | MIN. | 12/ 7/ 1986 | | | 8:02 A M |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| MD | | U.S.A | | | | Baltimore City, MD | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Baltimore | | Johns Hopkins Hospital | | | | NONE | | | | | |
| 13a. STATE | | | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | |
| MD | | | | BALTO | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 815 N. Bradford RT | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| JAMES McKethan | | | | STEPHANIE BROWN | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | |
| NO | | | | | | STEPHANIE BROWN 815 N. BRADFORD | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY: | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 9139 IMMEDIATE CAUSE (a) Compression Asphyxia | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last | | | | | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | | | |
| | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| | | | | ? P.M. 12/ 7/ 19 86 | | subject suffocated | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | | | | | |
| | | | | home | | 815 N. Bradford St., Balto. City, Md. | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | TITLE (SPECIFY) | | | | DATE SIGNED | | | |
| | | | | M.D. Assistant MEDICAL EXAMINER | | | | 12/8/86 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS | | | | | | | |
| Gregory R. Kauffman, M.D. | | | | 111 Penn St. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | | | |
| BURIAL | | 12/12/86 | | Mt Calvary | | G. G. County, MD, STATE | | | | | |
| 24. FUNERAL DIRECTOR | | | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Lanka Funeral Home | | | | 13047 N. Central | | DEC 11 1986 | | Julia Anderson-Randall | | | |
| | | | | | | DEC 11 1986 | | | | | |



028834 JAN

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) BEATRIX D. MCKINNEY | | 2a. DATE OF DEATH
MONTH DAY YEAR
12/26/86 | | 2b. HOUR
2:30 AM | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
06 07 14 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 6. AGE (IN YEARS LAST BIRTHDAY)
72 YRS.
MONTHS DAYS HOURS MIN. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
University Hospital | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOMEMAKER | | 12b. KIND OF BUSINESS OR INDUSTRY
Home | | 13a. STREET ADDRESS / ZIP CODE
7867 Baltimore & Annapolis Blvd.
21061 | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
M.D. | | 13b. COUNTY
Anne Arundel | | 13c. CITY OR TOWN
Glen Burnie | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Robert E. Brown | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Dorothy Miles | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | |
| 16b. SOCIAL SECURITY NO.
216-07-2540 | | 17. INFORMANT
Sharon Hoffman | | ADDRESS
355 Volley Ct.
Arnold, MD 21012 | |

| | | |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiopulmonary arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) Cerebral hemorrhage
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
|--|--|---|

| | |
|---|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):
Atrial Fibrillation, History of Myocardial Infarct | |
|---|--|

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from 10/18/86 to 12/26/86 , that (1) (we) lost
saw the deceased alive on 12/26/86 , and that in my (our) opinion death occurred on the date and hour and from the causes stated
above. (1) (we) did not view the body after death. | | | | | | | |
| 22b. SIGNATURE
Uri H. Hazzan M.D. | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
URI HHAZAN M.D. | | 22e. ADDRESS
225 Green Street | | | | | |

| | | | | | | | |
|--|--|----------------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) BURIAL | | 23b. DATE
Dec 29, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY
GLEN HAVEN MEM PK | | 23d. LOCATION
CITY OR TOWN STATE
Glen Burnie A.A. M.D. | |
|--|--|----------------------------------|--|--|--|---|--|

| | | | | | |
|--|--|--|--|--|--|
| 24. FUNERAL DIRECTOR
NAME
McGully Funeral Homes | | 25a. DATE REC'D BY REGISTRAR
DEC 30 1986 | | 25b. REGISTRAR'S SIGNATURE
Julia Beridon-Randall | |
|--|--|--|--|--|--|

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then place in the appropriate space on page 3. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other significant event, the medical examiner must be notified of such.

MEDICAL CERTIFICATION

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Page 1

Section D

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | | | | |
|---|---------|--|--|--|--|---|--|-------------------------|--|--------------------------|--|-------|--|------|--|-----------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2b. DATE KNOWN OF DEATH | | MONTH | | DAY | | YEAR | | 2b. HOUR | |
| Michael | | | | | | McKinney | | 12-19 | | 19 | | 86 | | | | M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | MONTH | | DAY | | YEAR | |
| male | black | 8 12 1954 | | 32 YRS. | | | | | | 12-20 | | 19 | | 86 | | 9:25 a. M | |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | |
| Md | | USA | | | | Baltimore City, | | | | | | | | | | MD | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | |
| Baltimore | | 3210 Walbrook Avenue | | Laborer | | | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | | | | | |
| Md | | | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 3210 Walbrook Avenue | | | | | | | | 21216 | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | |
| Jene | | McKinney | | Melba | | Foster | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | | | | | |
| NO | | 216-48-5098 | | Melba McKinney | | 1420 Pennsylvania Avenue | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | |
| PART 1 DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) | | Narcotic Intoxication | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | (b) | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | |
| | | (c) | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | | | | | | | | | | | | | |
| | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | |
| Primary | | 12-19 19 86 | | Subject used drugs | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | | | | | | | | | | | | | |
| | | Home | | 3210 Walbrook Ave, Baltimore, Maryland | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an | | Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | | | | | |
| death resulted from: | | Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | DATE SIGNED | | | | | | | | | | | | | |
| William M. Zane, M.D. | | Assistant | | 12-21-86 | | | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | | | | | | | | | | | | | | |
| William M. Zane, M.D. | | 111 Penn St., Balto., Md. | | 21201 | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | | | | | | | | | |
| Burial | | 12/27/86 | | Mt Zion Cemetery | | Lansdown | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | |
| March Funeral Home | | 1101 E. North Avenue | | DEC 30 1986 | | Julia Tension-Rodner | | | | | | | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETURN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M
BP 444
DHMH - 17
(VR A15 ME (5))

026494 DEC-98

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | |
|---|--|--|---|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
<u>JAMES L. McLAUGHLIN</u> | | | 2a. DATE OF DEATH
MONTH DAY YEAR
<u>12 6 86</u> | | 2b. HOUR
<u>8⁰⁰ P.M.</u> | |
| 3. SEX
<u>Male</u> | | 4. RACE
<u>White</u> | | 5. DATE OF BIRTH
MONTH DAY YEAR
<u>11 03 19</u> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<u>67</u> YRS. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<u>MARYLAND</u> | | 7b. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<u>Baltimore City</u> MD. |
| 10. CITY OR TOWN OF DEATH
<u>BALTIMORE</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<u>SOUTH BALTIMORE GENEX HOSPITAL</u> | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<u>RETIRED</u> | | 12b. KIND OF BUSINESS OR INDUSTRY
<u>Tavern Owner</u> |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE <u>MD</u> 13b. COUNTY <u>BALTIMORE</u> 13c. CITY OR TOWN <u>BALTIMORE</u> | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE <u>Balto. Md. 226 F BARNEY ST 21230</u> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<u>JAMES J. McLAUGHLIN</u> | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<u>MARIE W. MCCAFFREY</u> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<u>Yes</u> | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
<u>W.W.2 218031026</u> | | 17. INFORMANT <u>Lily V. W.</u> ADDRESS
<u>--- JAMES McLAUGHLIN AS ABOVE</u> | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARDIO RESP. ARREST</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Progressive Metastatic disease - liver failure</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>small cell carcinoma of the lung</u>
Approximate interval between onset and death
<u>3 months</u>
<u>3 months</u> | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>1</u> | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<u>P.M. 19</u> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12 / 02</u> , 19 <u>86</u> , to <u>12 / 06</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>12 / 06</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
<u>[Signature]</u> | | | | 22c. DATE SIGNED
<u>12/6/86</u> | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>Rony Perodromsky</u> | | | | 22e. ADDRESS
<u>BALTIMORE, MD 3001 S. HANOVER ST. 21230</u> | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<u>Burial</u> | | 23b. DATE
<u>12/10/1986</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Holy Cross Cemetery</u> | | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
<u>Balto. A.A.Co. Maryland</u> | | 24. FUNERAL DIRECTOR
NAME
<u>Balto. Md. 21230 McCully Funeral Home, 130 E. Fort Ave.</u> | | | | |
| 25a. DATE REC'D. BY REGISTRAR
<u>DEC 8 1986</u> | | | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | | |

MEDICAL CERTIFICATION

29

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the funeral director.

BP

05880-02-101



028855 JAN - 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the physician certify that the deceased was executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please enclose this certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 3 4 1 1

REG. NO.

| | | | | | | | | | | |
|---|--|---|--|---|--|--|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Sylvia McLaurin | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 25 86 | | | 2b. HOUR
8:03 PM | | | | |
| 3. SEX
Female | | 4. RACE
black | | 5. DATE OF BIRTH
MONTH DAY YEAR
11 30 40 | | 6. AGE (IN YEARS LAST BIRTHDAY)
46 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Balto., Md. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Balt city MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
ESK medical Ctr | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
Md | | | 13b. COUNTY
USA | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Robert Reid | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ruth Reid | | | 13e. STREET ADDRESS / ZIP CODE
5903 Radecke Ave 21206 | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
no | | | 16b. SOCIAL SECURITY NO.
219-38-8137 | | 17. INFORMANT
Wilson Nolley | | | | ADDRESS
5903 Radecke Apt F | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiopulmonary Arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) Chronic Obstructive Pulmonary Dis
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 405 (HT) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. ANATOMY
YES NO | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12-12 , 19 86 , to 12-25 , 19 86 , that (I) (we) last saw the deceased alive on 12-25 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Howard S. Tuch | | | | | DEGREE
MD | | 22c. DATE SIGNED
12-25-86 | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Howard S. Tuch | | | | | 22e. ADDRESS | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) Burial | | | 23b. DATE
12/31/86 | | 23c. NAME OF CEMETERY OR CREMATORY
Eastview | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto., Md. | | | |
| 24. FUNERAL DIRECTOR
NAME
Leroy O. Dyett | | | | | ADDRESS
46 00 Liberty Heights | | 25a. DATE REC'D. BY REGISTRAR
DEC 30 1986 | | 25b. REGISTRAR'S SIGNATURE
Julia Dandrea-Randall | |



DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25M

DHMH - 17
(VR A15 ME (5))

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE
EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PARAGRAPH 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES.
FOR BURIAL: AFTER DEATH, PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS,
AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 401 W. PRESTON STREET,
BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|---|---------------------------------|---|--|---|---|---|--|---|---|---|--|
| 1. DECEASED NAME
(Type or Print)
James H. McMillan | | | 2a. DATE KNOWN OF DEATH
<input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR
12/26/1986 | | | 2b. HOUR
5:30 P.M. | | | | | |
| 3. SEX
M | 4. RACE
B | 5. DATE OF BIRTH
MONTH DAY YEAR
July 31 1940 | | 6. AGE (IN YEARS LAST BIRTHDAY)
40 YRS. | 7. IF UNDER 1 YR.
MONTHS DAYS HOURS MIN.
0 0 0 0 | 7c. DATE PRONOUNCED DEAD
12/26/1986 | | | | | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | | 9b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
1240 Mapleleaf Court | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Baltimore City Sanitation | | 12b. KIND OF BUSINESS OR INDUSTRY
Baltimore City Sanitation | | | |
| 13a. STATE
Md. | 13b. COUNTY
Baltimore | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
1419 N. Bond St. 21213 | | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
James Harvey McMillan | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Rosa Manning | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
yes | | 16b. SOCIAL SECURITY NO.
213-46-1099 | | 17. INFORMANT
Rosie McMillan | | 17. ADDRESS
1419 N. Bond St. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Narcotic Intoxication
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
Primary | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
3 P.M. 12-26 1986 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
Subject used drug | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
House | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
1240 Mapleleaf Court, Baltimore, Md. | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE
Dennis F. Smyth | | | TITLE (SPECIFY)
Assistant | | | MEDICAL EXAMINER | | | DATE SIGNED
12/27/86 | | |
| EXAMINER'S NAME (TYPE OR PRINT)
Dennis F. Smyth, M.D. | | | ADDRESS
111 Penn St. | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
12-31-86 | | 23c. NAME OF CEMETERY OR CREMATORY
Garrison Forest Cem | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Owings Mill Md | | | |
| 24. FUNERAL DIRECTOR NAME
Wm. C. Marsh | | | | | | 24. ADDRESS
714 E. North Ave. | | 25a. DATE REC'D. BY REGISTRAR
DEC 30 1986 | | 25b. REGISTRAR'S SIGNATURE
D. J. Davidson | |

FOR
1- STATE
REGISTRAR
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|------------------|--|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
LACY A. MCNEILL | | 2a. DATE KNOWN OF DEATH
12-4-86 | | 2b. HOUR
M | |
| 3. SEX
male | 4. RACE
black | 5. DATE OF BIRTH
MONTH DAY YEAR
1 25 05 | 6. AGE [IN YEARS]
(LAST BIRTHDAY)
81 YRS. | 7. IF UNDER 1 YR.
MONTHS DAYS | 7. IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
N.C. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 7c. DATE PRONOUNCED DEAD
12-4-86 | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
4006 Main Avenue | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | |
| 13a. STATE
Md | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Tom | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Agnes McNeill | | 16. SOCIAL SECURITY NO.
217-05-2714 | |
| 17a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | 17b. INFORMANT
Maxine Thomas | | 17c. ADDRESS
1466 Haward Street N.W. Apt 203 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>arteriosclerotic cardiovascular disease</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | |
| 20a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 20b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | 21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21c. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that I took charge of the remains described above, and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .
(HEAD ONLY) Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/>
ACTUAL SIGNATURE <u>Margarita A. Korell</u> M.D. Assistant MEDICAL EXAMINER DATE SIGNATURE <u>12-5-86</u>
EXAMINER'S NAME (TYPE OR PRINT) <u>Margarita A. Korell, M.D.</u> ADDRESS <u>111 Penn Street</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
12/9/86 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt Auburn Cemetery | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
March Funeral Home West 4300 Wabash Avenue | | 25a. DATE REC'D. BY REGISTRAR
DEC 16 1986 | | 25b. REGISTRAR'S SIGNATURE
<u>Julia Sanders-Randall</u> | |

MEDICAL CERTIFICATION

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT, PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/B4
25M

BP
DHMH - 17
(VR A15 ME (5))

0575 17550

100% cotton fabric
100% cotton fabric



028890

-207
FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|---|--|--|--|---|--|---|---|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
ETHEL LONIE MCQUEEN | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 26 1986 | | | 2b. HOUR
p m
p | | | | | |
| 3. SEX
FEMALE | | 4. RACE
BLACK | | 5. DATE OF BIRTH
MONTH DAY YEAR
10 06 1889 | | 6. AGE (IN YEARS LAST BIRTHDAY)
97 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
N. CAROLINA | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
DUKELAND NURSING HOME | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MARYLAND | | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
3700 COPELY ROAD 21215 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Henry McQueen | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Lula | | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO --- | | | | 16b. SOCIAL SECURITY NO.
243-42-9085 | |
| 17. INFORMANT
ADDRESS
Sandra G Canary 4227 Buckman Rd. | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ASPIRATION PNEUMONIA
DUE TO, OR AS A CONSEQUENCE OF
(b) ASPIRATION OF FOOD
DUE TO, OR AS A CONSEQUENCE OF
(c) ---
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4 HRS | | | 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
ASCVD-CHF | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 29 SEPTEMBER, 1983, to 26 DECEMBER, 1986, that (I) (X) last saw the deceased alive on 13 DECEMBER, 1986, and that in my (X) opinion death occurred on the date and hour and from the causes stated above, (I) (X) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
ARTHUR M. LEBSON | | | DEGREE
M.D. | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
26 DECEMBER 86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ARTHUR M. LEBSON, M.D. | | | 22e. ADDRESS
3640 FORDS LANE BALTIMORE 21215 | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
12/31/86 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Auburn Cem | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Westport Md. | | 25a. DATE REC'D. BY REGISTRAR
DEC 30 1986 | | |
| 24. FUNERAL DIRECTOR
NAME
March Funeral 4300 Wabash Ave. | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE
A. J. Anderson | |

MEDICAL CERTIFICATION

BP B

DHMH - 16 50M 4/83
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove all burials. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

NYC 00-1

(1)

027595 DEC 19 1986

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|--|---|---|---|--------------------------|--|--|
| FOR STATE REGISTRAR
LUCILLE E. MEADOWS | | | | | | | | | |
| REG. NO. | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Lucille E Meadows | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12-16-86 | | 2b. HOUR
240AM | | |
| 3. SEX
FEMALE | | 4. RACE
WHITE C | | 5. DATE OF BIRTH
MONTH DAY YEAR
12-16-1918 | | 6. AGE (IN YEARS LAST BIRTHDAY)
68 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
IF UNDER 24 HRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN)
Summers Cnty, W. Va. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Balto City | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Mercy Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife-Homemaker | | | |
| 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE
MD | | 13b. COUNTY
Balto | | 13c. CITY OR TOWN
Balto | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 13e. STREET ADDRESS / ZIP CODE
303 S. EAST AVE 21224 | | | | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William M.F. Grimmer | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Cora Jane Fox | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
232-38-1981 | | 17. INFORMANT Baltimore, Md. 21224.
Mrs. Greta January-503 S. East Ave. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Probable Myocardial Infarction
DUE TO, OR AS A CONSEQUENCE OF
(b) Atherosclerotic Cardiovascular Disease
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 110. | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Dennis Kurgansky | | DEGREE
MD
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
12-16-86 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Dennis Kurgansky | | 22e. ADDRESS
301st Paul Place 21202 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
12/19/86 | | 23c. NAME OF CEMETERY OR CREMATORY
CrestLawn-Gardens | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
of Memories-Howard Cnty Md. | | | |
| 24. FUNERAL DIRECTOR John A. Moran, Inc. Funeral Home DATE REC'D. BY REGISTRAR | | | | | | | | | |
| 25. REGISTRAR'S SIGNATURE
John A. Moran, Inc. Funeral Home
3000 E. Baltimore St. Baltimore, Md. 21224
DEC 18 1986
John A. Moran, Inc. | | | | | | | | | |

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME

(TYPE OR PRINT)

JOHN

FIRST

MIDDLE

Curtis

LAST

MEDCALF, Jr.

2a. DATE OF DEATH

MONTH

DAY

YEAR

12

2

86

2b. HOUR

MIN.

1124

M

3. SEX

MALE

4. RACE

Caucasian

5. DATE OF BIRTH

MONTH

DAY

YEAR

4 16 16

6. AGE (IN YEARS LAST BIRTHDAY)

70

YRS.

IF UNDER 1 YEAR

IF UNDER 24 HRS.

MONTHS

DAYS

HOURS

MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Maryland

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

BALTO. CITY

MD.

10. CITY OR TOWN OF DEATH

BALTO.

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

SINAI HOSPITAL

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

District Supervisor

12b. KIND OF BUSINESS OR INDUSTRY

Culbro Corp.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

MD. BALTO

13b. COUNTY

RANDALLSTOWN

13d. INSIDE CITY LIMITS?

YES ☐ NO ☒

13e. STREET ADDRESS / ZIP CODE

LANAMER RD 21133

14. FATHER'S NAME

FIRST

MIDDLE

LAST

John CURTIS

MEDCALF, Jr.

15. MOTHER'S MAIDEN NAME

FIRST

MIDDLE

LAST

MYRA PECK

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE SERVICE AND DATES)

NO

16b. SOCIAL SECURITY NO.

216-10-2263

17. INFORMANT

Mrs. Barbara A. Medcalf 21133

3706 Lanamer Road Randallstown, MD.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Sudden Electro-mechanical Dissociation and Cardiac Arrest

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b)

Toxicologic Cardiac Catheterization (Due to IV Infusion or chamber perforation and related Cardiac Tamponade in a Pt. E Deceased heart)

DUE TO, OR AS A CONSEQUENCE OF

(c)

Asphyxiation by a Plastic Bag and Deceased heart

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERM, DISEASE OR CONDITION GIVEN IN PART I

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐AT WORK ☐ AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

Joseph Sabmon

DEGREE

M.D.

ATTENDING PHYSICIAN ☒MEDICAL DIRECTOR ☐STAFF PHYSICIAN ☐

22c. DATE SIGNED

12-2-86

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

Joseph Sabmon

22e. ADDRESS

Sinai Hospital

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b. DATE

12/5/86

23c. NAME OF CEMETERY OR CREMATORY

Lake View Mem. Park

23d. LOCATION

CITY OR TOWN

Sykesville

COUNTY

Carroll

STATE

MD.

24. FUNERAL DIRECTOR Loring Byers Funeral Directors, Inc.

NAME

ADDRESS

8728 Liberty Road

Randallstown, MD. 21133

25a. DATE REC'D. BY REGISTRAR

DEC 5 1986

25b. REGISTRAR'S SIGNATURE

Loring Byers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These papers, pages 1 and 2 should be filed in the office of the health officer with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified for removal.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|--|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | |
| 1. DECEASED NAME FIRST MIDDLE LAST
LESLIE Irrus MEDLOCK | | | | 2b. HOUR P
4:35 M | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
June 21, 1920 | | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.
66 | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Oklahoma | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE JOHNS HOPKINS HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Director | | 12b. KIND OF BUSINESS OR INDUSTRY
Aircraft Ind. | |
| 13a. STATE
Maryland | | 13b. COUNTY
Washington | | 13c. CITY OR TOWN
Hagerstown | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Claud Medlock | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Amanda Pasley | | 13e. STREET ADDRESS / ZIP CODE
2242 Briarcliff Drive 21740 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
663-24-0737 | | 17. INFORMANT ADDRESS
Zoe E. Medlock 2242 Briarcliff Drive Hagerstown, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Arrest
DUE TO, OR AS A CONSEQUENCE OF (b) Respiratory Failure
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c) Malignant Duodenal Carcinoma
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4 minutes
10 minutes
2 years | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/6/86 , 19 86 , to 12/6 , 19 86 , that (I) (we) last saw the deceased alive on 12/6 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Patrick C. Malloy MD | | DEGREE
MD | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
12/6/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Patrick C. Malloy MD | | 22e. ADDRESS
Dept. of Medicine Johns Hopkins Hospital | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
12-9-86 | | 23c. NAME OF CEMETERY OR CREMATORY
Rest Haven Cemetery Hagerstown, Washington, Md. | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| 24. FUNERAL DIRECTOR NAME
A.K. Coffman Funeral Home, Inc. | | ADDRESS
Hagerstown, Md. | | 25a. DATE REC'D. BY REGISTRAR
DEC 10 1986 | | 25b. REGISTRAR'S SIGNATURE
1 in Harrison-Pendall | |

BP

02661-1-113

NAME
U.S.A.

WHITE
U.S.A.

June 21, 1939

68

Director

Albion Ind.
21740

Washington Headquarters

2242 Brinkley Drive

Cland

Recluse

Amber

Basley

2242 Brinkley Drive
Hagerstown, Md.

68-25-0707 Sub E. Recluse

Yes



Best Haven Center, Hagerstown, Washington, Md.
A. A. Coffey Funeral Home, Inc.
Hagerstown, Md.

**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH**

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | |
|--|---|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
JAMES C. MEEKINS | | | 2a. DATE OF DEATH
MONTH DAY YEAR
DECEMBER 31, 1986 | | 2b. HOUR
10:41 PM |
| 3 SEX
Male | 4 RACE
white | 5. DATE OF BIRTH
MONTH DAY YEAR
Feb. 17, 1911 | | 6 AGE (IN YEARS LAST BIRTHDAY)
75 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b CITIZEN OF WHAT COUNTRY?
USA | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10 CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
MARYLAND GENERAL HOSPITAL | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Farmer Retired | 12b KIND OF BUSINESS OR INDUSTRY | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | 13b COUNTY
Baltimore | 13c CITY OR TOWN
Pikesville | 13d INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e STREET ADDRESS / ZIP CODE
26 Waldron Ave 21208 | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
Mose Meekins | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Susie Copper | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b SOCIAL SECURITY NO.
WW 2 218 14 4479 | | 17. INFORMANT
Charlotte Ritter ADDRESS
26 Waldron Ave 21208
Baltimore, Md. | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) RESPIRATORY ARREST and HEART ARREST

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
DUE TO, OR AS A CONSEQUENCE OF (b) RENAL FAILURE
DUE TO, OR AS A CONSEQUENCE OF (c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): | | | | | |
| 19a DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | |
| 21d INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22. I certify that (a) (this hospital) attended the deceased from December 22, 1986 to December 31, 1986 , that (we) last saw the deceased alive on December 31, 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (not) view the body after death. | | | | | |
| 22b. SIGNATURE
Henry Nammour M.D. | | DEGREE
M.D. | | 22c. DATE SIGNED
1-1-1987 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
HENRY NAMMOUR M.D. | | 22e. ADDRESS
c/o MARYLAND GENERAL HOSPITAL | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
1/2/87 | 23c. NAME OF CEMETERY OR CREMATORY
Chester Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Chestertown, Md. | |
| 24 FUNERAL DIRECTOR
NAME
J. Willis Wells | | ADDRESS
Chestertown, Md. | | 25a. DATE REC'D. BY REGISTRAR
JAN 06 1987 | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

026313 DEC-86

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, an medical examiner will be notified on item 18.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|---|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) ROBERT L. MEGENHARDT | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 12/2/86 | | | 2b. HOUR 16:59 PM | |
| 3. SEX male | | 4. RACE W | | 5. DATE OF BIRTH MONTH DAY YEAR 9/3/28 | | 6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. D.C. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Balto, City MD. | | | |
| 10. CITY OR TOWN OF DEATH Balto. | | NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hosp. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retired | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Md. | | 13b. COUNTY Balto. | | 13c. CITY OR TOWN | | 13e. STREET ADDRESS 6010 Montgomery St. 21227 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Frederick H... Megenhardt | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nancy L. Webster | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No (IF YES, GIVE WAR OR DATES) | | | | | 16b. SOCIAL SECURITY NO. 218-26-1817 | | 17. INFORMANT ADDRESS Dora Lee Megenhardt 6010 Montgomery St. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCT DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOCLEROTIC CARDIOVASCULAR DISEASE HEART DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH PAGE |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: ACUTE BRONCHOPNEUMONIA | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/2 , 19 86 , to 12/2 , 19 86 , that (I) (we) last saw the deceased alive on 12/2 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Steven H. Pearson DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | | 22c. DATE SIGNED 12/3/86 | | | | |
| 22a. PHYSICIAN'S NAME (TYPE OR PRINT) STEVEN H. PEARSON | | | | | 22b. ADDRESS ST. AGNES HOSPITAL 500 S. COTTON AVE. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 12-5-1986 | | 23c. NAME OF CEMETERY OR CREMATORY Lorraine Park | | 23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md. | | |
| 24. FUNERAL DIRECTOR NAME EDWARD J. WEBER FUNERAL HOME ADDRESS 5311 EDMONDSON AVE | | | | | 25a. DATE REC'D. BY REGISTRAR DEC 5 1986 | | 25b. REGISTRAR'S SIGNATURE Julia E. ... | | |

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 3 4 7 2 5

FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|-------------------------|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) JO ANN E. MEHLING | | 2a. DATE OF DEATH
MONTH DAY YEAR 12/4/86 | | 2b. HOUR 1:50 P.M. | |
| 3. SEX
FEMALE | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH DAY YEAR 10-1-40 | | 6. AGE (IN YEARS LAST BIRTHDAY)
46 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
BALTIMORE, Md | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 9. BALTIMORE CITY OR COUNTY OF DEATH
REISTERSTOWN, MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE, Md | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
BENT NURSING HOME | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
CLERICAL WORK | |
| 13a. STATE
Md. | | 13b. COUNTY
BALTIMORE | | 13c. STREET ADDRESS
237 GLYDON DR. 21136 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
OSCAR BURGER | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ELSIE Tracey | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
213-36-9186 | | 17. INFORMANT
ADDRESS
Mr. Robert L. Mehling Reisterstown, Md. | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1: DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

Huntington's Chorea

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH**Years**

PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED
(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4-19 19 84 to 12-4 19 86 , that (I) (we) last saw the deceased alive on 12-4 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (do) view the body after death. | | | | | | | |
| 22b. SIGNATURE
C.E. McWilliams MD | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12-4-86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
C.E. McWilliams M.D. | | 22e. ADDRESS
1190 Reisterstown Rd Reisterstown Md. 21136 | | | | | |

| | | | | | | | |
|---|--|-----------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
12/8/86 | | 23c. NAME OF CEMETERY OR CREMATORY
Holy Cross Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Md. | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Eline Funeral Home Reisterstown, Md. 21136 | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 8 1986 | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE
Julius D. [Signature] | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and place pages 1 and 2 in the envelope provided with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is checked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

08-01-97 15:06:35



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | REG. NO. | |
|---|--|--|---|--|----------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Mary Meisel | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 / 30 / 86 | | 2b. HOUR
545 A.M. | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Oct. 24, 1897 | | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
89 | | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Baltimore, Md. | | 8. CITIZEN OF WHAT COUNTRY?
USA | | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Union Memorial Hospital | | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
Home | | 13a. STREET ADDRESS / ZIP CODE
8112 Pleasant Plains Rd. 21204 | | |
| 13b. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Towson | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Frank Vavra | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Theresa ? | | 16. SOCIAL SECURITY NO.
215 10 3726 | | |
| 17. INFORMANT
Charles Vavra | | 18. ADDRESS
7122 Greenbank Rd.
Balto., Md. 21220 | | 19. DATE OF OPERATION | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 20b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | |
| 21a. INJURY OCCURRED
AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21b. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21c. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/26, 1986, to 12/30, 1986, that (I) (we) last saw the deceased alive on 12/30, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If two (do not) view the body after death.) | | 22b. SIGNATURE
S. O. Trerotola MD | | 22c. DATE SIGNED
12/30/86 | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
12/31/86 | | 23c. NAME OF CEMETERY OR CREMATORY
Gardens of Faith | | |
| 24. FUNERAL DIRECTOR
NAME
Brudzinski Funeral Home PA 1407 Old Eastern Ave | | 25a. DATE REC'D. BY REGISTRAR
JAN 2 1987 | | 25b. REGISTRAR'S SIGNATURE
John Bruden... | | |

Sept. 5, 1930

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U.S. Department of Justice

24

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026174 DEC 5 1986

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

E0282282

REG. NO.

| | | | | | | |
|--|--|---|--|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Audrey Evelyn Mellon | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 1 86 | | 2b. HOUR
7:54A | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
1 31 25 | | |
| 6. AGE (IN YEARS (LAST BIRTHDAY))
61 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
61 | | IF UNDER 24 HRS
HOURS MIN.
7:54A | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
St Agnes Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | |
| 12b. KIND OF BUSINESS OR INDUSTRY
Domestic | | | | | | |
| 13a. STATE Maryland 13b. COUNTY Baltimore 13c. CITY OR TOWN Lansdowne 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS / ZIP CODE 207 Fifth Ave., 21227 | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
James P. Daly, Sr. | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Elizabeth Hadel | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
220-14-8234 | | 17. INFORMANT
ADDRESS
Wilmer C. Mellon, Sr. Same as #13 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Anoxia
DUE TO, OR AS A CONSEQUENCE OF
(b) Cardiac Arrest
DUE TO, OR AS A CONSEQUENCE OF
(c) Arteriosclerotic Cardiovascular Disease
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
1. Diabetes; 2. Hypertension | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/17 , 19 86 , to 12-1 , 19 86 , that (I) (we) lost
saw the deceased alive on 12-1 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
Domingo C. Sorongon MD | | DEGREE
MD | | 22c. DATE SIGNED
12/1/86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Dr. Domingo C. Sorongon | | 22e. ADDRESS
St. Agnes Hospital Baltimore, Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
12/4/86 | | 23c. NAME OF CEMETERY OR CREMATORY
Glen Haven Mem Pk | | |
| 23d. LOCATION
(CITY OR TOWN) COUNTY STATE
Glen Burnie, AA Co., Md. | | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Mccully Funeral Homes Balto. Md. 21225 | | 25a. DATE REC'D. BY REGISTRAR
DEC 4 1986 | | 25b. REGISTRAR'S SIGNATURE
John Borden-Pandora | | |

MEDICAL CERTIFICATION

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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at home hospital

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027484 DEC 17 86

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

34729

FOR
1 - STATE
REGISTRAR

| | | | | | | | |
|---|--|--|--|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Gladys J. Melton | | | 2a. DATE OF DEATH
MONTH DAY YEAR
Dec. 11, 1986 | | 2b. HOUR
1:05 PM | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Nov. 29, 1910 | | | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
USA N.C. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Secretary | | 12b. KIND OF BUSINESS OR INDUSTRY
Seafood | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Mason F. Lord Chronic Hospital | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Balto. | | 13c. CITY OR TOWN
Balto. | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John Larkin Joyner | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Glendora Douglas | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
238-28-6250 | | 17. INFORMANT
ADDRESS
6548 Riverview Ave.
Mr. Charles Melton - Balto., Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1: DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiopulmonary Arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) Atherosclerotic Heart Disease
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
10 | | |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Multiple cerebral vascular accidents; Recent Pneumonia | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (this hospital) attended the deceased from July 31, 1986 to Dec. 11, 1986 , that (I) <input checked="" type="checkbox"/> saw the deceased alive on Dec 11, 1986 , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (did) <input type="checkbox"/> view the body after death. | | | | | | | |
| 22b. SIGNATURE
John Hoh, MD | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED
12-11-86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
John Hoh, M.D. | | 22e. ADDRESS
5200 Eastern Ave. Baltimore MD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Removal | | 23b. DATE
12-11-86 | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | |
| 24. FUNERAL DIRECTOR
NAME
Anatomy Board | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 15 1986 | | 25b. REGISTRAR'S SIGNATURE
John Davidson-Randall | |

MEDICAL CERTIFICATION

99

1

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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Group 7. 1941-1942
Franklin D. Roosevelt
USA
President of the United States

President of the United States
Franklin D. Roosevelt
1941-1942

1941-1942
Franklin D. Roosevelt
President of the United States

1941-1942
Franklin D. Roosevelt
President of the United States

026755 DEC 11 1986

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|--|--|---|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FRANK J. MERNAUGH, JR. | | | | 2a. DATE OF DEATH MONTH DAY YEAR 12-5-1986 | | | |
| 3 SEX Male | | | | 2b. HOUR 9:05 A.M. | | | |
| 4 RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 7-21-1914 | | 6 AGE (IN YEARS LAST BIRTHDAY) 72 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ind. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | |
| 10 CITY OR TOWN OF DEATH Baltimore | | | | 9 BALTIMORE CITY OR COUNTY OF DEATH Bethesda City MD. | | | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 340 S. Poppleton St. 21230 | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electrician | | 12b. KIND OF BUSINESS OR INDUSTRY R.R. | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE NAME OR ADMISSION) Ind. | | | | 13b. COUNTY Baltimore | | 13c. STREET ADDRESS / ZIP CODE 340 S. Poppleton St. 21230 | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Frank J. Mernaugh Sr. | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lehnert | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. 913-05-1744 | | 17 INFORMANT ADDRESS Louise R. Mernaugh 340 S. Poppleton St. 21230 | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Lung Cancer
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 1986 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from July 18 19 85 , to Dec 5 19 86 , that (I) (we) lost saw the deceased alive on Nov 26 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE George Taler, M.D. | | | | DEGREE ATTENDING PHYSICIAN MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED Dec 5, 1986 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) George Taler, M.D. | | | | 22e. ADDRESS 600 LG St. Baltimore, Md. 21230 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (TYPE) Burial | | 23b. DATE 12-8-1986 | | 23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cn. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Ind. | |
| 24. FUNERAL DIRECTOR NAME John J. Cross & Son, Inc. 901 | | | | 25a. DATE REGD. BY REGISTRAR DEC 08 1986 | | 25b. REGISTRAR'S SIGNATURE John Davidson-Henderson | |

BP

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4

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 34731

| | | | |
|---|--|--|--|
| FOR
STATE
REGISTRAR | | REG. NO. | |
| 1. DECEASED NAME
(TYPE OR PRINT) CLARA H Merritt | | 2a. DATE OF DEATH
MONTH DAY YEAR
12-26-86 | |
| 3 SEX
Female | | 2b. HOUR
6:30 AM | |
| 4 RACE
White | | 5 DATE OF BIRTH
MONTH DAY YEAR
10 25 98 | |
| 6a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Germany | | 6 AGE (IN YEARS LAST BIRTHDAY)
88 YRS. | |
| 7a. CITIZEN OF WHAT COUNTRY?
USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore MD. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 12b. KIND OF BUSINESS OR INDUSTRY
own Home | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Heritage Nursing Center | | 13a. STREET ADDRESS / ZIP CODE
4444 North Point Rd. 21219 | |
| 13a. STATE
MD | | 13b. COUNTY
BALTO | |
| 13c. CITY OR TOWN
BALTO | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Carl Petrick | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Bertha Not Known | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
215-05-7611 | |
| 17. INFORMANT
Doloris Gray | | ADDRESS
4444 North Point Blvd. 21219 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) SEPSIS
DUE TO, OR AS A CONSEQUENCE OF (b) DIABETE MELLITUS
DUE TO, OR AS A CONSEQUENCE OF (c) ORGANIC BRAIN SYNDROME | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c) | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21d. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | |
| 21e. LOCATION
STREET CITY OR TOWN COUNTY STATE | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/05/1986 to 12/25/1986 , that (I) (we) last saw the deceased alive on 12/25/1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
R. J. Rasmussen M.D. | | 22c. DATE SIGNED
12/26/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
K. PHARMASENA | | 22e. ADDRESS
#8, 16th AVE. MD 21225 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
12-29-86 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Parkwood | | 23d. LOCATION
Baltimore, Maryland STATE | |
| 24. FUNERAL DIRECTOR
NAME
Duda-Ruck Funeral Home of Dundalk | | 25a. DATE REC'D. BY REGISTRAR
DEC 29 1986 | |
| 25b. REGISTRAR'S SIGNATURE
John E. Smith | | 25c. REGISTRAR'S SIGNATURE
John E. Smith | |

026399 DEC-30

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|-----------------------------|--|---|---|-------------------------------|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
<i>Margaret Helen Merryman</i> | | | 2a. DATE OF DEATH
MONTH DAY YEAR
<i>12 4 86</i> | | 2b. HOUR
<i>11:05 A.M.</i> |
| 3. SEX
<i>Female</i> | 4. RACE
<i>CAUCASIAN</i> | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>10 1 15</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>71</i>
YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>Wash. D.C.</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Baltimore City.</i> MD. | |
| 10. CITY OR TOWN OF DEATH
<i>BALTIMORE</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Sinai Hospital</i> | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Secretary</i> | |
| 13a. STATE
<i>MD</i> | | 13b. CITY OR TOWN
<i>BALTIMORE</i> | | 13c. STREET ADDRESS / ZIP CODE
<i>3006 Northbrook Rd 20904</i> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>George Brick</i> | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>Nellie Murphy</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
<i>No</i> | | 16b. SOCIAL SECURITY NO.
<i>578-54-8653</i> | | 17. INFORMANT
<i>Thomas Merryman</i> ADDRESS
<i>63 Penny Lane BALTO., MD. 21209</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Respiratory arrest</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) <i>Coronary of the lung</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i>chronic obstructive pulmonary disease</i> | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED
(ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (H) (this hospital) attended the deceased from <i>11/28</i> , 19 <i>86</i> , to <i>12/4</i> , 19 <i>86</i> , that (H) (we) lost saw the deceased alive on <i>12/4</i> , 19 <i>86</i> , and that in (M) (our) opinion death occurred on the date and hour and from the causes stated above, (H) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<i>[Signature]</i> | | DEGREE
<i>MD</i> | | 22c. DATE SIGNED
<i>12/4/86</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>Borisy Wertheimer MD</i> | | 22e. ADDRESS
<i>5847B Western Rd. N. BALT. MD 21209</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(TYPE OR PRINT)
<i>Burial</i> | | 23b. DATE
<i>Dec 6, 1986</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Druid Ridge Cem</i> | |
| 23d. LOCATION
(CITY OR TOWN) COUNTY STATE
<i>Pikesville BALTO. MD</i> | | 25a. DATE REC'D. BY REGISTRAR
<i>DEC 5 1986</i> | | | |
| 24. FUNERAL DIRECTOR
<i>[Signature]</i> | | ADDRESS
<i>Owings Mills, Md.</i> | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | |

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MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please attach to the permit. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of office.

| ITEM: 17 per INFORMANT | | | | STATE OF MARYLAND | | | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|--|--|--|--|--|--|--|--|---|--|--|--|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR
6-671 1/16/91 cm | | | | DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
Robert William Merryman | | | | 2a. DATE OF DEATH MONTH DAY YEAR
12/1/86 | | | | 2b. HOUR
7:21 PM | | | | | | | |
| 3. SEX
Male | | | | 4. RACE
Black | | | | 5. DATE OF BIRTH MONTH DAY YEAR
11 5 35 | | | | 6. AGE (IN YEARS LAST BIRTHDAY)
51 YRS | | | | 7. UNDER 1 YEAR IF UNDER 24 HRS MONTHS DAYS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Baltimore, Md. | | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore, MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Sinai Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Laborer | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| 13a. STATE
Md | | | | 13b. COUNTY
None | | | | 13c. CITY OR TOWN
Baltimore | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 13e. STREET ADDRESS / ZIP CODE
3823 Reisterstown Rd. 21215 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Jenny Merryman | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
-0-0-0-0-0 | | | | 16b. SOCIAL SECURITY NO.
213-34-1140 | | | | 17. INFORMANT ADDRESS
EUNICE MERRYMAN
Eunice Merryman, 3823 Riesterstown Rd | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>CVA</u>
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| | | | | | | | | | | | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/26/86</u> 19 <u>86</u> to <u>12/1/86</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>12/1/86</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
<u>[Signature]</u> | | | | DEGREE | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED
12/1/86 | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Abasada | | | | 22e. ADDRESS
4 Montaigne Court. | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | 23b. DATE
12/5/86 | | | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Baltimore, Md. | | | | | | | |
| 24. FUNERAL DIRECTOR NAME
Law Funeral Home | | | | ADDRESS
4611 Park Heights Ave. | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 3 1986 | | | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | | | | | |

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | REG. NO. | |
|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) <u>John Wesley Hertz</u> | | | | 2a. DATE OF DEATH
MONTH <u>12</u> DAY <u>24</u> YEAR <u>86</u> | | 2b. HOUR
<u>5:30</u> P.M. | |
| 3 SEX
<u>Male</u> | | 4 RACE
<u>White</u> | | 5. DATE OF BIRTH
MONTH <u>9</u> DAY <u>11</u> YEAR <u>18</u> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<u>68</u> YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<u>Baltimore City</u> MD. | |
| 10. CITY OR TOWN OF DEATH
<u>Baltimore</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<u>Francis Scott Key Med Center</u> | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<u>Retired</u> | | 12b. KIND OF BUSINESS OR INDUSTRY
<u>Tavern Owner</u> | |
| 13a. STATE
<u>Md.</u> | | 13b. COUNTY
<u>Baltimore</u> | | 13c. CITY OR TOWN
<u>Baltimore</u> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST <u>Md.</u> MIDDLE <u>Mertz</u> LAST <u>Mertz</u> | | 15. MOTHER'S MAIDEN NAME
FIRST <u>W.E.</u> MIDDLE <u>Krueger</u> LAST <u>3308 Hudson Street</u> | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<u>No</u> | | 16b. SOCIAL SECURITY NO.
<u>212-07-3439</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Congestive Heart Failure</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Renal Failure</u> | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Diabetes</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<u>P.M.</u> <u>19</u> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/10</u> , 19 <u>86</u> , to <u>12/24</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>12/24</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>M. Fingerhood MD</u> | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
<u>12/24/86</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>M. Fingerhood</u> | | | | 22e. ADDRESS
<u>Francis Scott Key Medical Center</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
<u>Burial</u> | | 23b. DATE
<u>12-29-86</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Oak Lawn Cemetery</u> | | 23d. LOCATION
CITY OR TOWN <u>Eastwood, Balto.</u> COUNTY <u>Co., Md.</u> STATE | |
| 24. FUNERAL DIRECTOR
NAME <u>Charles S. Zeiler & Son Inc.</u> ADDRESS <u>901 S. Conkling St.</u> | | | | 25a. DATE REC'D. BY REGISTRAR
<u>DEC 29 1986</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Julia Davidson-Rodman</u> | |

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|---|---|--|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
MARIE V MESSENGER | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 02 86 | | | 2b. HOUR
4:20 PM | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
6 19 1918 | | 6. AGE (IN YEARS LAST BIRTHDAY)
68 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTO. CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNIVERSITY OF MARYLAND | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOMEMAKER | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MD | | 13b. COUNTY
BETHESDA | | 13c. CITY OR TOWN
PASADENA | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Roy James Littleton | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Josephine | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | |
| 16b. SOCIAL SECURITY NO.
215-09-819 | | 17. INFORMANT
ADDRESS
630 DOVER RD
ALBERT C. MESSENGER PASADENA MD 21122 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARDIO-RESPIRATORY ARREST</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>CARDIOGENIC SHOCK</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>MYOCARDIAL INFARCTS</u> | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | |
| 19a. DATE OF OPERATION
12/1/86 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Temporary pace-maker insertion | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/1, 1986, to 12/2, 1986, that (I) (we) last saw the deceased alive on 12/2, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Thuy Nguyen MD | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
12/2/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
THUY VI NGUYEN | | | | 22e. ADDRESS
University of Maryland Hosp. | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
12-6-86 | | 23c. NAME OF CEMETERY OR CREMATORY
Glen Haven Mem. Park | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Glen Burnie Anne Arundel Md. | |
| 24. FUNERAL DIRECTOR
NAME
McCully F.H. 3204 Mountain Rd. Pasadena, Md. | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 8 1986 | | 25b. REGISTRAR'S SIGNATURE
Jill Anderson-Pandora | |

MEDICAL CERTIFICATION

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|---|----------------------|---|--|---|---|---|---|---|--|--|--|
| 1. DECEASED NAME
(Type or Print) Dorthy M. Middleton | | | | | | | | | | 2a. DATE KNOWN OF DEATH
MONTH DAY YEAR
12/ 26/ 86 | |
| 3. SEX
F. | 4. RACE
B. | 5. DATE OF BIRTH
MONTH DAY YEAR
8 8 08 | 6. AGE (IN YEARS)
(LAST BIRTHDAY)
78 YRS. | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS.
HOURS MIN. | | 7c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
12/26/ 19 86 | | 2b. HOUR
2:25 P.M. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
md. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
201 N. Washington St. | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
md | | | 13b. COUNTY | | 13c. CITY OR TOWN
Balto | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
21231 APT 400 201 N. Washington St | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Wesley | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Cook | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
NO | | | | 16b. SOCIAL SECURITY NO.
217-12-5587 | | 17. INFORMANT
ADDRESS
Charles Brown Sr. 129 N. Broadway apt 2 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a. | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE
Dennis F. Smyth | | | | | | TITLE (SPECIFY)
Assistant | | | MEDICAL EXAMINER | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Dennis F. Smyth, M.D. | | | | | | ADDRESS
111 Penn St. | | | DATE SIGNED
12/27/86 | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
12/30/86 | | 23c. NAME OF CEMETERY OR CREMATORY
King PK. | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto County | | | |
| 24. FUNERAL DIRECTOR
NAME
Wm. C. March F/H | | | | | | ADDRESS
1101 E. North Avenue | | 25a. DATE REC'D. BY REGISTRAR
DEC 30 1986 | | 25b. REGISTRAR'S SIGNATURE
Julia Benson-Radner | |



DEC 30 1956

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove pages 1 and 2 and send them to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause of death, the medical examiner must be notified.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | |
|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
MARGARET T MIHM | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12/02/86 | | 2b. HOUR
1515 M |
| 3. SEX
Female | 4. RACE
caucasian | 5. DATE OF BIRTH
MONTH DAY YEAR
8 8 13 | | 6. AGE (IN YEARS LAST BIRTHDAY)
73 yrs. YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE CITY | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
ST. AGNES HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE 13b. COUNTY 13c. CITY OR TOWN
Maryland Baltimore Arbutus | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
1026 Elmridge Ave. 21229 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Henry Mueller | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Margaret Keller | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
215 28 4738 | | 17. INFORMANT ADDRESS
George H. Mihm 1026 Elmridge Ave. 21229 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION, ACUTE
DUE TO, OR AS A CONSEQUENCE OF
(b) THROMBOSIS, RIGHT CORONARY ARTERY
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
PULMONARY EDEMA | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Michael E. Pelczar | | DEGREE
M.D. | | 22c. DATE SIGNED
12/3/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MICHAEL E. PELCZAR M.D. | | 22e. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
burial | | 23b. DATE
12/6/86 | | 23c. NAME OF CEMETERY OR CREMATORY
Meadowridge Mem. Park | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Elkridge Howard Md. | | 23e. DATE REC'D. BY REGISTRAR
DEC 3 1986 | | | |
| 24. FUNERAL DIRECTOR
NAME
Gary L. Kaufman | | 5695 Main St. Elkridge Md. | | 25a. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | |

BP

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100-2-1000

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | |
|---|--|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
Maria B. Miles | | 2a. DATE KNOWN OF DEATH
MONTH DAY YEAR
12 22 19 86 | | 2b. HOUR
10:45 P.M. |
| 3. SEX
Female | 4. RACE
black | 5. DATE OF BIRTH
MONTH DAY YEAR
1 21 1950 | 6. AGE (IN YEARS)
LAST BIRTHDAY
36 YRS. | 7. IF UNDER 24 HRS.
MONTHS DAYS HOURS MIN.
IF UNDER 1 YR. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
721 N. Payson Street | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Unemployed | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | |
| 13a. STATE
Md | 13b. COUNTY | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
721 N. Payson Street 21217 |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Carroll | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Albertina Bethea | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
212-56-5266 | 17. INFORMANT
ADDRESS
Albertina Carroll 5004 Goodman Road Apt B | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Morphine Intoxication</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR PRIMARY CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
<u>subject used drug</u> | | 21b. TIME OF INJURY
HOUR MONTH DAY YEAR
? (P.M.) 12 22 19 87 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
home | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
721 N. payson St. Baltimore, City, Md. |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> . | | | | |
| ACTUAL SIGNATURE
 | | TITLE (SPECIFY)
M.D. Assistant MEDICAL EXAMINER | | DATE SIGNED
12/23/86 |
| EXAMINER'S NAME (TYPE OR PRINT)
Gregory R. Kauffman, M.D. | | ADDRESS
111 Penn St. Balto.MD. | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | 23b. DATE
12/27/86 | 23c. NAME OF CEMETERY OR CREMATORY
Mt Zion Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Lansdown Md |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
March Funeral Home 1101 E. North Avenue | | 25a. DATE REC'D. BY REGISTRAR
DEC 30 1986 | | |
| | | 25b. REGISTRAR'S SIGNATURE
 | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXCLUDE THE CERTIFICATE, WRITING THE WORD "PENDING" THEREIN IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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FOR
1- STATE
REGISTRAR

REG. NO.

| | | | | | | | |
|--|--|--|--|--|----------------------------|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
CHARLES H. MILLER | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12/14/86 | | 2b. HOUR
1:55 AM | | |
| 3. SEX
M | | 4. RACE
CAU | | 5. DATE OF BIRTH
MONTH DAY YEAR
12 14 41 | | 6. AGE (IN YEARS LAST BIRTHDAY)
45 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE MD | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
North Charles Gen. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Respiratory Therapist | | 12b. KIND OF BUSINESS OR INDUSTRY
Health | |
| 13a. STATE
MD | | 13b. CITY OR TOWN
Belcamp | | 13c. STREET ADDRESS, ZIP CODE
1203 Halls Lane 21017 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Charles H. Miller | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ALBERTA CRIDER | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
190 32 0623 | |
| 17. INFORMANT
ADDRESS
Alberta Miller 700 Maple St. Brockway, PA. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pneumonia
DUE TO, OR AS A CONSEQUENCE OF (b) Acquired Immunodeficiency Syndrome
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.
Mycobacterium Avium Intracellulare; CMV Retinitis | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOMAT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART II) | | | |
| 22a. INJURY OCCURRED | | 22b. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 22c. LOCATION
STREET CITY OR TOWN COUNTY STATE
12/14/86 | | | |
| 22d. I certify that (1) (this hospital) attended the deceased from 1985 to 12/14/86 and that in my (our) opinion death occurred on the date and hour and from the causes stated | | | | | | | |
| 22e. SIGNATURE
Donald M. Pachuta | | | | DEGREE
ATTENDING PHYSICIAN MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22f. DATE SIGNED
12/14/86 | |
| 22g. PHYSICIAN'S NAME (TYPE OR PRINT)
Donald M. Pachuta | | | | 22h. ADDRESS
2903 N. Charles St Baltimore MD 21201 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
12-17-86 | | 23c. NAME OF CEMETERY OR CREMATORY
Wildwood Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Brockway, Jefferson, Pennsylvania | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
MARZULLO FUNERAL SERVICE UPPERCOR, MD | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 16 1986 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked for item 18 shows any injury, or other traumatic event, the medical examiner may be notified at once.

BP

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 34740

1- STATE REGISTRAR

| | | | | | | | | | | | |
|--|---------|--|--|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF ESTI-
DEATH MATED <input checked="" type="checkbox"/> MONTH DAY YEAR | | 2b. HOUR | |
| Ethel | | Miller | | | | | | 12-3 19 86 | | M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH
MONTH DAY YEAR | | 6. AGE (IN YEARS)
(LAST BIRTHDAY) | | IF UNDER 1 YR.
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN | | 2c. DATE
PRONOUNCED DEAD | |
| Female | Col 2 | 5-9-38 | | 58 YRS. | | | | | | 12-3 19 86 | |
| 7a. BIRTHPLACE (STATE OR
FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | 2d. HOUR | |
| BALTIMORE MD | | U. S. A | | | | Baltimore City, | | | | 11:03 a.m. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS
OR INDUSTRY | | | | | |
| Baltimore | | Liberty Medical Center | | None | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS | | | |
| MARYLAND | | | | BALTIMORE | | | | 2217 MONTICELLO RD 21216 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | | | | | | | | |
| CHARLES | | MARCELLA FORD | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | |
| No | | | | McHARDY MILLER | | 2217 MONTICELLO RD | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Hypertensive Arteriosclerotic Cardiovascular Disease</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a. | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR
CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | TITLE (SPECIFY)
M.D. Deputy Chief | | | | DATE SIGNED 12-4-86 | | | |
| EXAMINER'S NAME
(TYPE OR PRINT) | | | | ADDRESS | | | | | | | |
| Ann M. Dixon, M.D. | | | | 111 Penn St., Balto., Md. 21201 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY COUNTRY STATE | | | | | |
| Burial | | 12-8-86 | | Kearney Forest V.A. | | BALTO MD | | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| JASON L. RUSO 23224 NORTH AVE | | | | DEC 12 1986 | | Julia D. Dixon | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

OF THE

1917

OFFICE OF THE
CHIEF OF BUREAU

1917

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. This page must have carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to funeral, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
MARK EDWARD MILLER, JR. | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
12 27 86 | | 2b. HOUR
10:45 AM | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
11 27 17 | | 6. AGE (IN YEARS LAST BIRTHDAY)
69 YRS | | 7. IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore city MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
1727 St. Paul Street | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Carpenter | | 12b. KIND OF BUSINESS OR INDUSTRY
Construction | |
| 13a. STATE
Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
1727 St. Paul Street 21202 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Mark E. Miller, Sr. | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Cora Elizabeth Sutch | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
YES | | | | 16b. SOCIAL SECURITY NO.
217-07-2267 | | 17. INFORMANT ADDRESS
Katherine E. Willey 2307 Herkimer St. 21230 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiac arrest</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>arrhythmia</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Myocardial Coronary Heart Disease</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Possible malnutrition</u> | | | | | | | | | |
| 19a. DATE OF OPERATION
N/A | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
N/A | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 12 27 1986 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)
N/A | | | | | |
| 21d. INJURY OCCURRED AT HOME <input type="checkbox"/> NOT AT HOME <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
N/A | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1975</u> , 19 <u>July 13</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>July 13</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>Deborja</u> | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
12 27 86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Deborja | | | | 22e. ADDRESS
1115 N. Calvert Street | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | 23b. DATE
12/28/86 | | 23c. NAME OF CEMETERY OR CREMATORY
Secretary Process Crematory | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Catonsville Baltimore Md. | | | |
| 24. FUNERAL DIRECTOR NAME
Hubbard Funeral Home, Inc. | | | | 24b. ADDRESS
4107 Wilkens Ave. | | 25a. DATE REC'D. BY REGISTRAR
DEC 29 1986 | | 25b. REGISTRAR'S SIGNATURE
<u>Julia Davidson-Randall</u> | |

1

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

0634742

REG. NO.

| | | | | | |
|--|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
John E. Minderlein | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 23 1986 | | 2b. HOUR
0945 AM | |
| 3. SEX
M | 4. RACE
C | 5. DATE OF BIRTH
MONTH DAY YEAR
01 28 1911 | | 6. AGE (IN YEARS LAST BIRTHDAY)
75 YRS. | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
md. | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Pl's home: 738 S. Curley Street | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Truck Driver | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
md. | 13b. COUNTY | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John Conrad Minderlein | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Elizabeth Wiesner | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
210-01-6484 | 17. INFORMANT ADDRESS
Carl Minderlein Rd 2, Delta Pa 17314 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) PRESUMED CARDIAC ARRHYTHMIA
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
minutes
minutes |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)
Chronic renal failure anemia history of congestive heart failure | | | | | |
| 19a. DATE OF OPERATION
N/A | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
N/A | 20a. AUTOPSY
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) this hospital attended the deceased from 6/16 19 86 to 10/21 19 86 , that (2) (we) last saw the deceased alive on 10/21 19 86 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (3) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Melvin Hector | | DEGREE
MD | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
12/23/86 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Melvin Hector | | 22e. ADDRESS
Francis Scott Key Medical Center Balto, Md | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | 23b. DATE
12/26/86 | 23c. NAME OF CEMETERY OR CREMATORY
Schwartz Cem. | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Md. | | |
| 24. FUNERAL DIRECTOR
NAME
Lilly & Zeiler Inc. | | ADDRESS
1901 Eastern Ave. | | 25a. DATE REC'D. BY REGISTRAR
DEC 24 1986 | 25b. REGISTRAR'S SIGNATURE
Julia Soderstrom-Randall |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by letter.

2002-2003
2003-2004
2004-2005

028404 DEC 30 1986

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the container. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 3 4 1 / 4 3

REG. NO.

| | | | | | | |
|---|--|---|--|--|----------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
LEROY Gruber METZ | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 16 86 | | 2b. HOUR
16:00 M | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
11 5 11 | | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
75 YRS. | | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Hagerstown | | 8. IF UNDER 1 YEAR
MONTHS DAYS
75 | | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH
BALT CITY MD. | | 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNIV OF MARYLAND | | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
accountant | | 12b. KIND OF BUSINESS OR INDUSTRY
railroad | | 13a. STREET ADDRESS / ZIP CODE
33 BROADWAY 21740 | | |
| 13b. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13c. CITY OR TOWN
HAGERSTOWN | | 13d. STREET ADDRESS / ZIP CODE
33 BROADWAY 21740 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William C. Metz | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Nellie Gruber | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
yes WW II | | |
| 16b. SOCIAL SECURITY NO.
705-10-5593 | | 17. INFORMANT
Mary W. Metz | | 18. ADDRESS
33 Broadway Hagerstown, Md 21740 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE
DUE TO, OR AS A CONSEQUENCE OF
(b) AORTIC STENOSIS
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | |
| 19a. DATE OF OPERATION
12-16-86 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
AORTIC STENOSIS | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | |
| 21c. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21d. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21e. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12-16 , 19 86 , to 12-18 , 19 86 , that (I) (we) last saw the deceased alive on 12-18 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
Luat Duckett | | 22c. DEGREE
MD | | 22d. DATE SIGNED
12-16-86 | | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)
LUAT DUCKETT | | 22f. ADDRESS | | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | |
| 23b. DATE
Dec. 20, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY
Fairview Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Mercersburg Pa. | | |
| 24. FUNERAL DIRECTOR
NAME
Minnich Funeral Home | | 25a. DATE REC'D. BY REGISTRAR
DEC 24 1986 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | |



2008 COLLECTION FIELD

BP

DHMH - 16 60M 7/B4
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director. Page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 86 34744 | | | |
|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) <u>HILDA T MILNES</u> | | | | 2a. DATE OF DEATH MONTH DAY YEAR
<u>12 26 86</u> | | | |
| 3. SEX
<u>F Female</u> | | 4. RACE
<u>W White</u> | | 5. DATE OF BIRTH
MONTH DAY YEAR
<u>7 7 12 12 14 4</u> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<u>72 7 2</u> YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<u>Maryland</u> | | 7b. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<u>Baltimore City</u> MD. | |
| 10. CITY OR TOWN OF DEATH
<u>BALTIMORE</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<u>FRANCIS SCOTT KEY</u> | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<u>RETIRED</u> | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE <u>MD</u> 13b. COUNTY <u>BALTO.</u> | | | | 13c. CITY OR TOWN
<u>BALTO</u> | | 13d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<u>RODOLPH</u> | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<u>Anna Tabor</u> | | 13e. STREET ADDRESS / ZIP CODE
<u>2023 LARCHALL RD, DUNDALK MD 21222</u> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<u>No</u> | | 16b. SOCIAL SECURITY NO.
<u>213-14-0583</u> | | 17. INFORMANT
<u>George Milnes</u> Same as Above | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARDIOVASCULAR ARREST</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>MYOCARDIAL ISCHAEMIA</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>CARDIOMYOPATHY</u> | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>hrs</u>
<u>years</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>None</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<u>P.M. 19</u> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/25</u> , 19 <u>86</u> , to <u>12/26</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>12/26</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>C. Potter</u> MD | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
<u>12/26</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>C. POTTER</u> | | | | 22e. ADDRESS
<u>4940 EASTERN AVE BALTO MD 21224</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<u>Cremation</u> | | 23b. DATE
<u>12-29-86</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Westview Memorial</u> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<u>Baltimore Maryland</u> | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
<u>Duda-Ruck Funeral Home of Dundalk, Inc.</u>
<u>7922 Wise Ave Dundalk, Md 21222</u> | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
<u>DEC 29 1986</u> | | | |

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition. Medical examiner must be notified at once. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|---|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | 20. DATE OF DEATH MONTH DAY YEAR 12 11 86 | | | |
| 2. DECEASED NAME (TYPE OR PRINT) ISABELLE MILLER | | | | 2b. HOUR 11:38 A.M. | | | |
| 3. SEX Female | | 4. RACE Col 2 | | 5. DATE OF BIRTH MONTH DAY YEAR 9-25-1894 | | 6. AGE (IN YEARS LAST BIRTHDAY) 92 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN) Baltimore, Md. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Liberty med Center | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY 13c. CITY OR TOWN Baltimore | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 5 South Abingtown 21229 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William Henry Downs | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Harriet James | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Mr. Frank Williams 5 S. Abingtown St 21229 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOGENIC SHOCK. DUE TO, OR AS A CONSEQUENCE OF (b) MYOCARDIAL INFARCTION. DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: RESPIRATORY FAILURE. ARHYTHMIAS | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHITE <input type="checkbox"/> NO: WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11-24, 19 86, to 12-11, 19 86, that (I) (we) last saw the deceased alive on 12-11, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Bich T Duong | | | | DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 12-11-86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) BICH T DUONG | | | | 22e. ADDRESS LIBERTY MEDICAL CENTER. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 12-17-86 | | 23c. NAME OF CEMETERY OR CREMATORY Baltimore Nat Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co. Md. | |
| 24. FUNERAL DIRECTOR NAME Joseph L. Russ FUNERAL 2222 W NORTH AVE. | | | | 25a. DATE REC'D. BY REGISTRAR DEC 19 1986 | | 25b. REGISTRAR'S SIGNATURE Julia Davidson-Richard | |

3

028338 DEC 22 1986

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|---|--|--|--|--|--|--|--|--|--|--|--|
| 1- FOR STATE REGISTRAR | | | | | | | | | | 7a. DATE KNOWN OF DEATH | |
| DECEASED NAME
(NAME OR PRINT) Shawn Gary Miller | | | | | | | | | | 7b. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 12/21/1986 | |
| 2. SEX Male 3. RACE White 4. DATE OF BIRTH MONTH DAY YEAR June 12, 1970 5. AGE (IN YEARS) (LAST BIRTHDAY) 16 YRS. 6. IF UNDER 1 YR. MONTHS DAYS 7. IF UNDER 24 HRS. HOURS MIN. | | | | | | | | | | 7c. DATE PRONOUNCED DEAD 12/21/1986 | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, D.C. 9. CITIZEN OF WHAT COUNTRY? U.S.A. 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 11. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD | | | | | | | | | | 12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) STUDENT 13. KIND OF BUSINESS OR INDUSTRY EDUCATION | |
| 14. CITY OR TOWN OF DEATH Baltimore 15. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Francis Scott Key Medical Center 16. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) WEST VIRGINIA 26757 17. CITY OR TOWN ROMNEY 18. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 19. STREET ADDRESS 185 NORTH BOLTON ST. 26757 | | | | | | | | | | 20. FATHER'S NAME FIRST MIDDLE LAST CLAVIN G. MILLER 21. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SHELVA JUDY | |
| 22. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO 23. IF YES, GIVE WAR OR DATES ----- 24. SOCIAL SECURITY NO. 235-17-8084 25. INFORMANT ADDRESS CALVIN G. MILLER ROMNEY, WEST VIRGINIA | | | | | | | | | | 26. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Thermal Injuries
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) DUE TO, OR AS A CONSEQUENCE OF
(c) | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a. Cerebral Trauma | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 21b. TIME OF INJURY HOUR MIN. MONTH DAY YEAR 2:50 P.M. 12/20/1986 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) auto caught driver of auto/fixed object collision/fire | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) roadway 21f. LOCATION STREET CITY OR TOWN COUNTY STATE Rt. #29, Slanesville, W. Virginia | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: <input type="checkbox"/> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | |
| ACTUAL SIGNATURE [Signature] M.D. Assistant MEDICAL EXAMINER 23. TITLE (SPECIFY) DATE SIGNED 12/22/86 | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Gregory R. Kauffman, M. D. ADDRESS 111 Penn St. | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL BURIAL 23b. DATE DEC. 26, '86 23c. NAME OF CEMETERY OR CREMATORY WESLEY CHAPEL CEMETERY 23d. LOCATION CITY OR TOWN COUNTY STATE POINTS, WEST VIRGINIA | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS WILLIAM E. JOHNSON 8521 LOCH RAVEN BLVD. 25a. DATE OF CERTIFICATE 12/22/1986 25b. REGISTRAR SIGNATURE [Signature] | | | | | | | | | | | |

FORM 1 - 17
(VR A15 ME (5))

MAILED

NOV 20 1882



029354 JAN 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

| | | | | | | | | |
|---|-----------------------|---|---|---|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FRANK L. MITCHELL | | | 2a. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR
12 27 19 86 | | | 2b. HOUR
M
11:38 A | | |
| 3. SEX
Male | 4. RACE
Wk. | 5. DATE OF BIRTH
MONTH DAY YEAR
12/25/1911 | 6. AGE (IN YEARS)
LAST BIRTHDAY
75 YRS. | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | IF UNDER 24 HRS. | 2c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
12 29 19 86 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Florida | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
711 Cumberland St. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
MD. | | 13b. COUNTY | 13c. CITY OR TOWN
Balt. City | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
711 Cumberland St. | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Tom Mitchell | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Sarah Mitchell | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
W.W. II | | | 16b. SOCIAL SECURITY NO.
247-164654 | | 17. INFORMANT
ADDRESS
Andrew Lewis 2521 Salem St | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).
Diabetes mellitus | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | 20. AUTOPSY?
Head Only
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described above, held on
death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>
Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | |
| ACTUAL SIGNATURE William M. Zane | | | TITLE (SPECIFY)
M.D. Assistant MEDICAL EXAMINER | | | DATE SIGNED 12-29-86 | | |
| EXAMINER'S NAME
(TYPE OR PRINT) William M. Zane, M.D. | | | ADDRESS 111 Penn St., Balto., MD 21201 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL | | 23b. DATE
1/6/87 | 23c. NAME OF CEMETERY OR CREMATORY
St. V.A. Cem. Garrison-Forest | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore City Md. | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Conall 1712 W. North Ave | | | 25a. DATE REC'D. BY REGISTRAR
JAN 5 1987 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGE 1, 2 AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM MW 3. RETURN PAGE 5 TO YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

07/B4
25M

BP

DHMH - 17
(VR A15 ME (5))

STANDARD
LABORATORY

% COLICIN



11



026461 DEC

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

97/104
25M

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PM 3. BEHIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BASIS FOR THE DEATH CERTIFICATE. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

#18a, & 22a., G-623, by Med. Ex. STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | | | | | | | | | | |
|--|---------|--|--|--|--|---|--|---|--|--------------------------|--|---|--|------|--|--|--|--|--|-------|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH | | MONTH | | DAY | | YEAR | | 2b. HOUR | | | | | | | |
| ANGEL | | | | MOCERE | | | | 12-5-86 | | 19 | | | | | | M | | | | | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | MONTH | | DAY | | YEAR | | | | | | | |
| Female | White | 5 1 84 | | 2 1/2 YRS. | | | | | | 12-5-86 | | 19 | | | | 8:44a | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | MD. | | | | | | | |
| Maryland | | USA | | | | Baltimore City | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT AT HOME, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | |
| Baltimore | | Francis Scott Key Medical Center | | Dependant | | | | | | | | | | | | | | | | | | | |
| 13a. STATE | | 13b. CITY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | | | | | | | | | | | |
| Maryland | | Baltimore | | Eastwood | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 7245 Stratton Way | | | | | | | | 21224 | | | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | | | | | | |
| James | | Lisa | | Mocere | | Lisa | | J. Walters | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | | | | | | | | | | | |
| No | | NONE | | James L. Mocere | | Same as 13e. | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Acute bronchiolitis and epiglottitis | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. | | | | | | | | | | | | | | | | | | | | | | | |
| (b) | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? | | | | | | | | | | | |
| | | | | | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | | | |
| | | | | P.M. 19 | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET | | | | CITY OR TOWN | | | | COUNTY | | | | STATE | | | |
| | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | TITLE (SPECIFY) | | | | | | | | DATE SIGNED | | | | | | | | | | | |
| Margarita A. Korell, M.D. | | | | M.D. Assistant | | | | | | | | 12-5-86 | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS | | | | | | | | | | | | | | | | | | | |
| | | | | 111 Penn Street | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION CITY OR TOWN | | | | COUNTY | | | | STATE | | | |
| Burial | | | | 12-9-86 | | | | Oak Lawn | | | | Baltimore Maryland | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME | | | | 25a. DATE REC'D. BY REGISTRAR | | | | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | |
| Duda-Ruck Funeral Home of Dundalk | | | | DEC 8 1986 | | | | | | | | Julia Davidson-Randall | | | | | | | | | | | |
| 7922 Wise Ave. DUNDALK, MD 21222 | | | | | | | | | | | | | | | | | | | | | | | |

DHMH - 17
(VR A15 ME (5))

0500000000

[Faint, illegible text and markings, possibly bleed-through from the reverse side of the page.]

027704 DEC 18 1986
MORRIS
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 3 4 7 4 9

REG. NO.

| | | | | | |
|--|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
FRANKLIN DELANOR R. MONROE | | | 2a. DATE OF DEATH
MONTH DAY YEAR
December 13, 1986 | | 2b. HOUR
2 P.M. |
| 3. SEX
Male | 4. RACE
Black | 5. DATE OF BIRTH
MONTH DAY YEAR
4 14 33 | 6. AGE (IN YEARS LAST BIRTHDAY)
53 YRS | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY, MD. | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
2821 W. Mulberry Street | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
UNEMP. | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
Maryland | | 13b. COUNTY | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
2821 W. Mulberry Street 21223 |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Thornton Monroe | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Clara Davis | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
YES | | 16b. SOCIAL SECURITY NO.
229385702 | | 17. INFORMANT ADDRESS
Nonie Thompson 4201 1/2 Gelston Drive | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive Heart Failure
DUE TO, OR AS A CONSEQUENCE OF
(b) Dilated Cardiomyopathy
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
Renal Failure - Liver Failure - alcohol's liver disease | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (a) this hospital attended the deceased from 12/7 to 12/7, 1986, that (we) lost saw the deceased alive on 12/7, 1986, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (b) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Radfat Y. Girgis | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Radfat Y. Girgis | | 22e. ADDRESS
500 N. Rolling Rd. Catonsville Md | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | 23b. DATE
12/18/86 | 23c. NAME OF CEMETERY OR CREMATORY
Garrison Forest VA | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Owings Mills, Md. | | |
| 24. FUNERAL DIRECTOR
NAME
March Funeral Homes 1101 East North Avenue | | | 25a. DATE REC'D. BY REGISTRAR
DEC 17 1986 | | |
| | | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it is completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies, page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment. The medical examiner must be notified if death was sudden or unexpected. If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified as soon as possible.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

16 FOR
STATE
REGISTRAR

| | | | | | | | |
|---|--|---|--|--|--|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
JAMES H. LOORE | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 18 86 | | | 2b. HOUR
4 40 AM | |
| 3. SEX
MALE | 4. RACE
BLACK | 5. DATE OF BIRTH
MONTH DAY YEAR
01 21 18 | | 6. AGE (IN YEARS LAST BIRTHDAY)
68 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
North Carolina | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE MD | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNIVERSITY OF MARYLAND HOSP. | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired. | | 12b. KIND OF BUSINESS OR INDUSTRY
American Stanley | |
| 13a. STATE
Maryland | | 13b. COUNTY
Baltimore | 13c. CITY OR TOWN
City | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
1922 Harlem Av. Balt. Md. 21217 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Arch - Moore | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Lenda - Williams. | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<input checked="" type="checkbox"/> | | 16b. SOCIAL SECURITY NO.
12-31-17 | | 17. INFORMANT
ADDRESS
DR. ARISTIMUNO UMHS. - Dept. Medicine. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
888 IMMEDIATE CAUSE (a) cardiopulmonary arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
congestive heart failure, ejection fraction = 12%; hx of arrhythmias. | | | | | | | |
| 19a. DATE OF OPERATION
— | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
— | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK
NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Nov. 11 19 86 , to Dec. 18 19 86 , that (I) (we) last saw the deceased alive on Dec. 17 19 86 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
B. Aristimuno MD | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
12/18/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
B. ARISTIMUNO | | | | 22e. ADDRESS
UMHS 225 Greene St. Balt. Md. 21201 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
12-24-86 | | 23c. NAME OF CEMETERY OR CREMATORY
Garris Forrest | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balt. Md. | |
| 24. FUNERAL DIRECTOR
NAME
James A. Morton + Sons | | | | ADDRESS
1701 Laurens St. | | 25a. DATE REC'D BY REGISTRAR
DEC 23 1986 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Rodman | | | |

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026397 DEC 1986

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) John P. Moore Sr. | | | 2a. DATE OF DEATH
MONTH 12 DAY 2 YEAR 86 | | | 2b. HOUR
10:15A | | | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH 4 DAY 28 YEAR 11 | | 6. AGE (IN YEARS LAST BIRTHDAY)
75 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS | | 8. IF UNDER 24 HRS
HOURS MIN. | |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 10. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 11. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 12. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | |
| 13. CITY OR TOWN OF DEATH
Baltimore | | 14. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
4142 6th Street (Home) | | | | 15. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Mfrgr Engineer | | 16. KIND OF BUSINESS OR INDUSTRY
Westinghouse | | | |
| 17. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
17a. STATE Maryland | | 17b. CITY OR TOWN
Baltimore | | 17c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 17d. STREET ADDRESS / ZIP CODE
4142 6th Street 21225 | | | | | |
| 18. FATHER'S NAME
FIRST Gary MIDDLE Washington LAST Moore | | | | 19. MOTHER'S MAIDEN NAME
FIRST Reita MIDDLE Anne LAST Phillips | | | | 20. ADD Baltimore Md 21210 | | | |
| 21. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No | | 22. SOCIAL SECURITY NO.
214-07-8582 | | 23. INFORMANT
John P. Moore Jr 501 W. University Parkway | | | | | | | |
| 24. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) metastatic prostate cancer
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
6 mos. | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: | | | | | | | | | | | |
| 25. DATE OF OPERATION | | 26. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 27. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 28. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 29. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 30. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 31. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 32. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 33. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 34. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 35. I certify that (a) (this hospital) attended the deceased from Sept 25 19 86 to Dec 2 19 86 , that (we) last saw the deceased alive on Sept 25 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (b) (we) (did) (not) view the body after death. | | | | | | | | | | | |
| 36. SIGNATURE
David D. Collins MD DEGREE MD | | | | | | | | | | 37. DATE SIGNED
12/2/86 | |
| 38. PHYSICIAN'S NAME (TYPE OR PRINT)
David D Collins, MD | | | | | | | | | | 39. ADDRESS
500 W. University Pkwy 21210 | |
| 40. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 41. DATE
12/6/86 | | 42. NAME OF CEMETERY OR CREMATORY
Glen Haven Mem Park | | 43. LOCATION
CITY OR TOWN COUNTY STATE
Glen Burnie A.A. Md | | | | | |
| 44. FUNERAL DIRECTOR
George J. Gonce 4001 Ritchie Hgwy Balto Md | | | | | | 45. DATE REC'D BY REGISTRAR
DEC 5 1986 | | 46. REGISTRAR'S SIGNATURE
John Deane-Randall | | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove couples papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

BP

029558 JAN - 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 3 4 / 5 2

REG. NO.

| | | | | | | | |
|--|--|---|---|--|--|--|--|
| 1 DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Lugenia Moore | | | 2a DATE OF DEATH
MONTH DAY YEAR
12 31 86 | | | 2b HOUR
4:40 M | |
| 3 SEX
FEMALE | | 4 RACE
BLACK | | 5 DATE OF BIRTH
MONTH DAY YEAR
5 21 1911 | | 6 AGE (IN YEARS LAST BIRTHDAY)
75 YRS. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
SOUTH CAROLINA | | 7b CITIZEN OF WHAT COUNTRY?
U.S. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Baltimore city MD | |
| 10 CITY OR TOWN OF DEATH
BALTO. | | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
MT. SINAI NURSING HOME | | | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Domestic | |
| 13a STATE
MD. | | 13b COUNTY | | 13c CITY OR TOWN
BALTO. | | 13d INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
WADE INGRAM | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ANNIE | | 13e STREET ADDRESS / ZIP CODE
3800 W. BELVEDERE, 21215 | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b SOCIAL SECURITY NO.
24409-12720 | | 17 INFORMANT
ADDRESS
KELLUM INGRAM 3602 FAIRVIEW | | | |

| | | |
|--|--|--|
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Atherosclerotic Cardiovascular Disease
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
years |
|--|--|--|

| | | | |
|--|--|--|--|
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20a AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | |
| 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21d INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | |
| 21e PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a I certify that (I) (this hospital) attended the deceased from 10/19/86 to 12/31/86 , that (I) (we) lost saw the deceased alive on 12/10/86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | |
| 22b SIGNATURE
Barbara Cochran | | DEGREE
CO | |
| 22c DATE SIGNED
12-31-86 | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)
BARBARA A. COCHRAN, MD | | 22e ADDRESS
6506 PAUL HEIGHTS AVE., BALTO, MD 21215 | |

| | | | | | | | |
|--|--|-----------------------------|--|---|--|--|--|
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b DATE
01-03-87 | | 23c NAME OF CEMETERY OR CREMATORY
MT. ZION CEM. | | 23d LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE MARYLAND | |
| 24 FUNERAL DIRECTOR
NAME ADDRESS
BROWN-TOMPSON Funeral Home 1913 W. BALTO ST. | | | | 25a DATE REC'D. BY REGISTRAR
JAN 6 1987 | | 25b REGISTRAR'S SIGNATURE
<i>John Division, Dundas</i> | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then place in the container with the deceased. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial. (Important: If item 21 is marked or item 18 shows any injury, or other significant event, the medical examiner must be notified.)

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other significant event, the medical examiner must be notified.

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove certification. Page 2 should be filed with 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|---|---|--|--|--|--|
| FOR
1. STATE
REGISTRAR | | | | | REG. NO. | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
MARGARET C. MOORE | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
12 21 86 | | | 2b. HOUR
5 50 AM | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
8 02 35 | | 6. AGE (IN YEARS LAST BIRTHDAY)
51 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SOUTH BALTIMORE GENERAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF LIFE)
C.P.A. | | 12b. KIND OF BUSINESS OR INDUSTRY
ACCOUNTING | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
Annapolis | | 13c. CITY OR TOWN
Glen Burnie | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
307 LONGWOOD AVE 21061 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
HARRY ROTH | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
SOPHIA MARIE CREAMER | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
214244245 | | 17. INFORMANT
ADDRESS
HARRY E. MOORE (SAME AS 13c) | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARDIO RESPIRATORY ARREST</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>PULMONARY EMBOLISM</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>ACUTE MYOCARDIAL INFARCTION</u>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>CONTRIBUTING TO DEATH</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>
AT HOME <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11-08</u> , 19 <u>86</u> , to <u>12-21</u> , 19 <u>86</u> , that (I) (we) lost
saw the deceased alive on <u>12-21-86</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
PATRICIA Steadman | | | | DEGREE
MD | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
12-21-86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
PATRICIA STEADMAN | | | | 22e. ADDRESS
3001 SOUTH HANOVER ST 21230 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | 23b. DATE
12-24-86 | | 23c. NAME OF CEMETERY OR CREMATORY
Westview Memorial pk | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Catonsville Balto. Md. | | | |
| 24. FUNERAL DIRECTOR
NAME
George Gonce | | | | ADDRESS
4001 Ritchie Hwy Baltimore Md. | | 25a. DATE REC'D. BY REGISTRAR
DEC 22 1986 | | 25b. REGISTRAR'S SIGNATURE
Julia J. [Signature] | |

100

027743 016-2786

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | |
|---|-------------------------|---|--|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
DANIEL L. MORIARTY Jr. | | | 2a. DATE KNOWN OF DEATH
<input checked="" type="checkbox"/> MONTH DAY YEAR
12-12-86 | | | 2b. HOUR
M | | |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
April 10, 1928 | 6. AGE (IN YEARS)
BIRTHDAY YRS.
58 | IF UNDER 1 YR.
MONTHS DAYS
15 | IF UNDER 24 HRS.
HOURS MIN.
15 | 7c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
12-12-86 | | 7d. HOUR
1:40P |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New Jersey | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
South Baltimore Co. General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK)
Engineer | | 12b. KIND OF BUSINESS
Westinghouse |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Anne Arundel | | 13c. CITY OR TOWN
Glenburnie | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Daniel L Moriarty Sr, | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Helen L Moriarity O'Brien | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES OR UNKNOWN)
Yes | | | 16b. SOCIAL SECURITY NO.
150 16 7201 | | 17. INFORMANT
ADDRESS
Daniel L Moriarty 210 Midpines Ct Apt 2 B Owings Mills 21117 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pneumonia with cirrhosis of the liver
DUE TO, OR AS A CONSEQUENCE OF
(b) alcoholism
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).
diabetes mellitus | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | |
| ACTUAL SIGNATURE
<i>[Signature]</i> | | | M.D. Chief | | | MEDICAL EXAMINER
DATE SIGNED 12-13-86 | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
John E. Smialek, M.D. | | | ADDRESS
111 Penn Street | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
Dec. 17'86 | | 23c. NAME OF CEMETERY OR CREMATORY
Good Shepherd | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Ellicott City Howard Md. | |
| 24. FUNERAL DIRECTOR
NAME
Harry H Witzke & Family Funeral Home | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 18 1986 | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/B4
25M

BP
DHMH - 17
(VR A15 ME (5))

037712 00000

NEW JERSEY
U.S.A.
JAN 10 1938

NEW JERSEY
U.S.A.
JAN 10 1938
NEW JERSEY
U.S.A.
JAN 10 1938

NEW JERSEY
U.S.A.
JAN 10 1938

NEW JERSEY
U.S.A.
JAN 10 1938

28492 DEC 30 86

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|------------------|---|---|---|---|---|-----------------------------------|
| 1. DECEASED NAME
(TYPE OR PRINT)
MILANA F. MORGAN | | | 2a. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR
12 15 1986 | | | 2b. HOUR
M
2:37 | |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
11-5-1986 | 6. AGE (IN YEARS)
LAST BIRTHDAY YRS.
7 YRS. | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | IF UNDER 24 HRS. | 2c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
12 15 1986 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Bon Secour Hospital | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Baby | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
Md. | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Thomas Reager | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Virginia Morgan | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
- | |
| 17. INFORMANT
Virginia Morgan | | 17a. ADDRESS
616 S. Monroe St. 21223 | | 17b. CITY OR TOWN
Baltimore | | 17c. STATE
Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Sudden infant death syndrome
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.
(b) DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE
William M. Zane, M.D. | | TITLE (SPECIFY)
M.D. Assistant | | MEDICAL EXAMINER | | DATE SIGNED 12/16/86 | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | 111 Penn St. Balto. MD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(TYPE OR PRINT)
Burial | | 23b. DATE
12-15-1986 | | 23c. NAME OF CEMETERY OR CREMATORY
Glen Haven Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Glen Burnie, G.G. Co. Md. | |
| 24. FUNERAL DIRECTOR
John J. Conner & Son Inc. | | 24a. ADDRESS
901 Shiloh St. Baltimore, Md. 21223 | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE
John J. Conner | |

07/84
25M

BP
DHMH - 17
(VR A15 ME (5))

JUL 22 1986

20X-0110-10

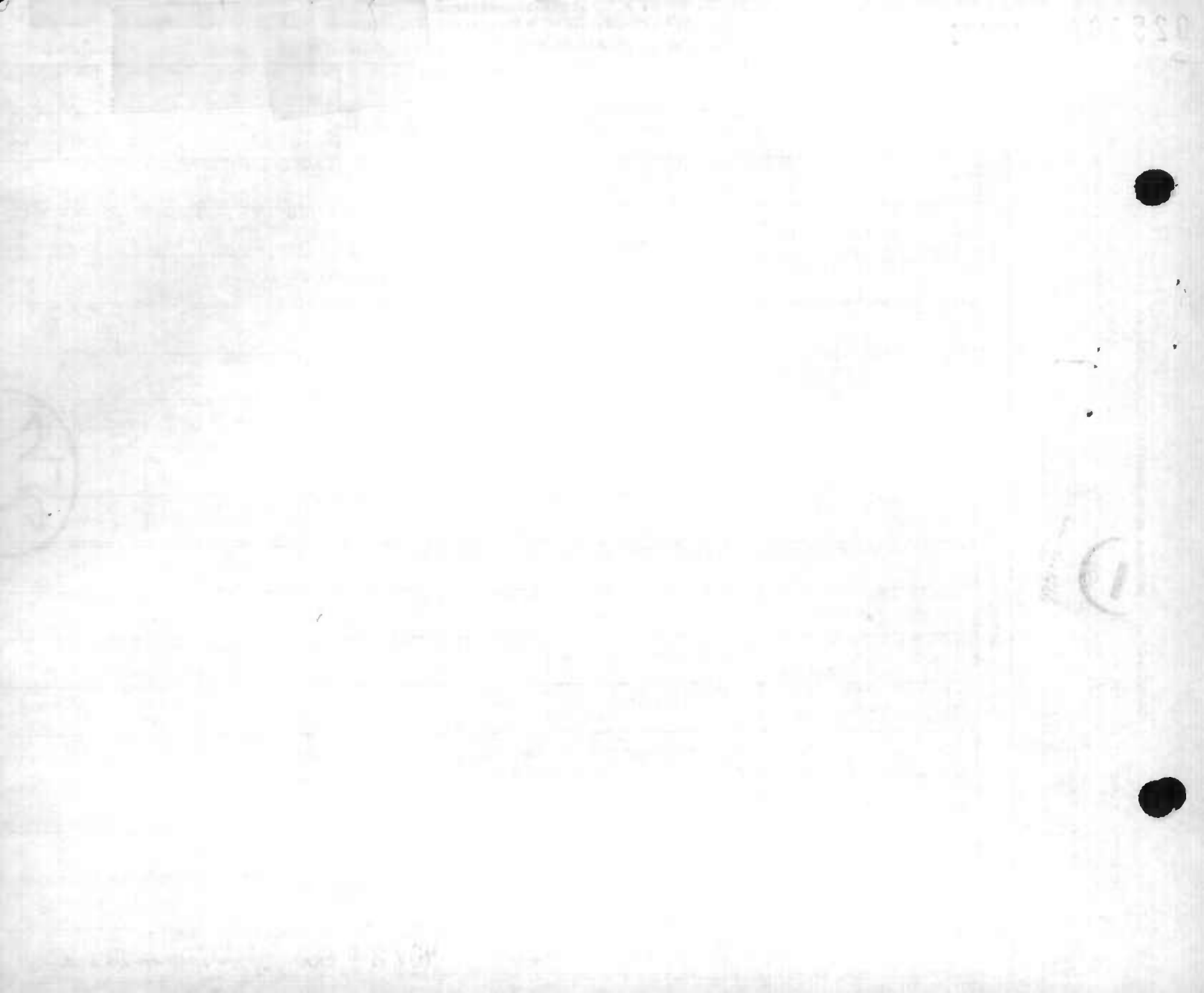
20X-0110-10



| | | | | | |
|--|-------------------------|---|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
BRENDA J. MOODY | | | 2a. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR
11 21 19 86 | | 2b. HOUR
M
10:10 A |
| 3. SEX
Female | 4. RACE
Black | 5. DATE OF BIRTH
MONTH DAY YEAR
4 18 49 | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS.
37 | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN.
 | IF UNDER 24 HRS.
 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
North Carolina | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City | | 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
2412 Llewelyn Ave. | |
| 12a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Willie Moody, Jr. | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Anna M. Harlee | | 16. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Unemployed | |
| 17a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
Unknown | | 17b. SOCIAL SECURITY NO.
219-52-4598 | | 17c. INFORMANT
ADDRESS
Jerry Moody 1809 Winford Road | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Multiple drug intoxication
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 11 21 19 86 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
Subject used drugs. | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
home | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
2412 Llewelyn Ave. Baltimore, Md. | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: <input checked="" type="checkbox"/> Natural causes <input type="checkbox"/> Accidents <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> and in my opinion | | | | | |
| ACTUAL SIGNATURE
<i>Charles P. Kokes</i> | | TITLE (SPECIFY)
M.D. Assistant | | DATE SIGNED
11-21-86 | |
| EXAMINER'S NAME (TYPE OR PRINT)
Charles P. Kokes, M.D. | | ADDRESS
111 Penn St., Balto., MD 21201 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
11/25/86 | | 23c. NAME OF CEMETERY OR CREMATORY
Baltimore Cemetery | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Md. | | 24. FUNERAL DIRECTOR
NAME ADDRESS
March Funeral Homes 1101 East North Avenue | | 25a. DATE REC'D. BY REGISTRAR
NOV 24 1986 | |
| 25b. REGISTRAR'S SIGNATURE
<i>Julia Davidson-Randall</i> | | | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201



26947 DEC 15 1986

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|---|--|---|--|---|--|--|--|--|--|----------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Flora Moore | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
December 10, 1986 | | | 2b. HOUR
3:00 AM | | | |
| 3. SEX
Female | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
8 21 20 | | 6. AGE (IN YEARS LAST BIRTHDAY)
66 | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
S.C. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
3404 W. Franklin St. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
MD | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
3404 W. FRANKLIN ST. 21229 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
ROBERT COVINGTON | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
FLORA JONES | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | | | 16b. SOCIAL SECURITY NO.
224328602 | | 17. INFORMANT
ADDRESS
ADOLPHUS MOORE 3404 W. FRANKLIN ST. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma lungs</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) <u>Primary Carcinoma left breast</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Recurrent Car skin + axilla</u>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>6 months</u>
<u>3 years</u>
<u>1 year</u> | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Mild adult onset diabetes</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION
<u>Jan 17 1985</u> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
<u>Carcinoma left breast</u> | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5-3-84</u> , 19 <u>84</u> , to <u>Dec 10</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>Dec 9 10:00</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>S.G. Sullivan M.D.</u> | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
<u>12-10-86</u> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>S.G. Sullivan</u> | | | | 22e. ADDRESS
<u>1129 St Paul St Baltimore Md.</u> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
12-13-86 | | 23c. NAME OF CEMETERY OR CREMATORY
CHURCH CEMETERY | | 23d. LOCATION
CITY/TOWN COUNTY STATE
LAURINBURG, N.C. | | | | | |
| 24. FUNERAL DIRECTOR
NAME <u>Wm. C. March F/H</u> 4300 Wabash Ave. | | | | 25a. DATE REC'D. BY REGISTRAR
<u>DEC 11 1986</u> | | 25b. REGISTRAR'S SIGNATURE
<u>John B. ...</u> | | | | | |

BP

1. The first part of the report is a summary of the work done during the year. It includes a list of the projects completed and a brief description of each. It also includes a list of the people who worked on the projects and a brief description of their roles.

2. The second part of the report is a detailed description of the work done on each project. It includes a list of the tasks completed and a brief description of each. It also includes a list of the people who worked on the tasks and a brief description of their roles.

3. The third part of the report is a list of the conclusions reached during the year. It includes a list of the conclusions reached on each project and a brief description of each. It also includes a list of the people who reached the conclusions and a brief description of their roles.

4. The fourth part of the report is a list of the recommendations made during the year. It includes a list of the recommendations made on each project and a brief description of each. It also includes a list of the people who made the recommendations and a brief description of their roles.

5. The fifth part of the report is a list of the conclusions reached during the year. It includes a list of the conclusions reached on each project and a brief description of each. It also includes a list of the people who reached the conclusions and a brief description of their roles.

027302 DEC 15 1986

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR | |
| DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | M | |
| JOHN S. MORAN, III | | December 12, 1986 | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | |
| MALE | | W | | 05 03 21 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. AGE (IN YEARS LAST BIRTHDAY) | |
| Md. | | USA | | 65 YRS. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| BALTIMORE | | GOODSAMARITAN HOSPITAL | | Baltimore City, MD. | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Serv. Mgr | | Scales | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | |
| Md. | | | | Baltimore | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| John Alonzo Moran II | | Eleanor F. Voigt | | 13e. STREET ADDRESS / ZIP CODE | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| Yes | | WW II | | Mrs. Jane N. Moran 1230 Cedarcroft Rd. -39 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | |
| IMMEDIATE CAUSE (a) Cerebrovascular Accident, with Infarction | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Pulmonary Edema | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12-7-1986, to 12-12-1986, that (I) (we) lost saw the deceased alive on 12-12-1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | |
| Lokeswararao Edara | | MD | | 12-12-86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| LOKESWARARAO, EDARA | | To Good Samaritan Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Entombment | | 12/15/86 | | Dulaney Valley | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE | | 23e. DATE REC'D. BY REGISTRAR | | 23f. REGISTRAR'S SIGNATURE | |
| Timonium, Md. | | DEC 15 1986 | | Julia Dink... | |
| 24. FUNERAL DIRECTOR NAME ADDRESS | | | | | |
| MITCHELL-WIEDEFELD HOME, INC. 6500 York Rd. | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|---|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR <i>1-5-87 A.L. per phone</i> | | | | 2a. DATE OF DEATH MONTH DAY YEAR 12-21-86 21 86 | | | |
| DECEASED NAME (TYPE OR PRINT) <i>LILLIAN MORRIS</i> | | | | 2b. HOUR 2:20 AM | | | |
| 3 SEX <i>F</i> | | 4 RACE <i>BLACK</i> | | 5. DATE OF BIRTH MONTH DAY YEAR 4 26 87 | | 6 AGE (IN YEARS LAST BIRTHDAY) 99 YRS. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>md.</i> | | 7b CITIZEN OF WHAT COUNTRY? <i>U.S.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore city</i> MD. | |
| 10. CITY OR TOWN OF DEATH <i>BALTIMORE</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>SOUTH BALTIMORE GENERAL</i> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a STATE <i>Md</i> | | 13b COUNTY <i>BALTO</i> | | 13c CITY OR TOWN <i>BALTO</i> | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e STREET ADDRESS / ZIP CODE <i>301 W. Franklin St. 21201</i> | | 14 FATHER'S NAME FIRST MIDDLE LAST <i>ALLEN DAVIS</i> | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>ANNA DAVIS</i> | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i> | | 16b SOCIAL SECURITY NO. <i>218-22-4716</i> | | 17 INFORMANT ADDRESS <i>Lena Washington 1808 P. Bentaba St.</i> | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>CARDIORESPIRATORY ARREST</i>
DUE TO, OR AS A CONSEQUENCE OF (b) <i>MASSIVE MYOCARDIAL INFARCTION</i>
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____ | | | | | | | |
| 19a DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>12-16</i> , 19 <i>86</i> , to <i>12-21</i> , 19 <i>86</i> , that (I) (we) last saw the deceased alive on <i>12-21</i> , 19 <i>86</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <i>Patricia Steadman</i> | | DEGREE <i>MD</i> | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED <i>12-21-86</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>PATRICIA S STEADMAN</i> | | 22e. ADDRESS <i>3001 SOUTH HANOVER ST BALTIMORE</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | 23b. DATE <i>12/23/86</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Maryland Nat.</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore P.G. md</i> | |
| 24. FUNERAL DIRECTOR NAME <i>Nancy Wallace</i> | | ADDRESS <i>3405 W. Franklin</i> | | 25a. DATE REC'D. BY REGISTRAR <i>DEC 29 1986</i> | | 25b. REGISTRAR'S SIGNATURE <i>Julia Dindon</i> | |

[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "SECRET" and "CONFIDENTIAL" are visible.]

026337 DEC

Film G622 item 16b
 FOR STATE 12/11/86 rja
 REGISTRAR

STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|---|---|---|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
<i>William Morris</i> | | | 2a. DATE OF DEATH
MONTH DAY YEAR
<i>12 1 86</i> | | | 2b. HOUR
<i>8 am</i> | | | |
| 1. SEX
<i>Male</i> | | 4. RACE
<i>W</i> | | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>4 29 12</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>74</i> YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>Virginia</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Baltimore City</i> MD. | | | |
| 10. CITY OR TOWN OF DEATH
<i>Baltimore</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Francis Scott Key med Ctr</i> | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Crown Cork & Seal Co</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>manufacturing</i> | |
| 13a. USUAL RESIDENCE (IF MISSING, HOME OR OTHER INSTITUTION; GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE <i>MD</i> 13b. COUNTY <i>BALTO.</i> 13c. CITY OR TOWN <i>Baltimore</i> | | | | 13d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 13e. STREET ADDRESS / ZIP CODE
<i>1203 Willow Road, 21222</i> | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>Francis Monroe Morris</i> | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>Ludellia Morris</i> | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>Yes</i> | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
<i>WW II</i> | | 17. INFORMANT
<i>Margaret G. Morris</i> | | ADDRESS
<i>1203 Willow Rd. 21222</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Cardiopulmonary Arrest</i>
DUE TO, OR AS A CONSEQUENCE OF:
(b) <i>Aspiration</i>
DUE TO, OR AS A CONSEQUENCE OF:
(c) <i>Stroke</i> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>30 min</i>
<i>?</i>
<i>1 month</i> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:
<i>Intra MI, Depression</i> | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<i>19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>11/23</i> , 19 <i>86</i> , to <i>12/1</i> , 19 <i>86</i> , that (I) (we) last saw the deceased alive on <i>12/1</i> , 19 <i>86</i> , and that in <input checked="" type="radio"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input type="radio"/> (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<i>Russell L. Margolis, MD</i> | | | DEGREE
<i>MD</i> | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
<i>12/1/86</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>Russell L. Margolis, M.D.</i> | | | 22e. ADDRESS
<i>FSKMC 4940 Eastern Ave.</i> | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
<i>Burial</i> | | | 23b. DATE
<i>12-4-86</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Bel Air Memorial</i> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Belair Harford MD</i> | | |
| 24. FUNERAL DIRECTOR
NAME
<i>Duda-Ruck Funeral Home of Dundalk</i> | | | ADDRESS
<i>7922 Wise Ave. Dundalk, MD 21222</i> | | | 25a. DATE REC'D. BY REGISTRAR
<i>DEC 5 1986</i> | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use at the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment. IMPORTANT: If item 18 is marked question 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

026745 DEC 11 1986

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 34761

| | | | | | | | |
|---|--|---|--|--|--|---|---|
| FOR
1. STATE
REGISTRAR | | 2a. DATE OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | |
| DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | |
| Bernard | | Paul | | MORRISON, Sr. | | 12 9 86 250 M | |
| 3 SEX | | 4 RACE | | 5. DATE OF BIRTH | | 6 AGE (IN YEARS LAST BIRTHDAY) | |
| Male | | White | | Aug. 13 12 | | 74 YRS. | |
| 7a BIRTHPLACE (STATE OR FOREIGN) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | |
| West Virginia | | USA | | | | Baltimore City MD. | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b KIND OF BUSINESS OR INDUSTRY | |
| Baltimore City | | South Baltimore Gen Hospital | | Salesman | | Dept. Store | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b COUNTY | | 13c CITY OR TOWN | | 13d INSIDE CITY LIMITS? | |
| Maryland | | Baltimore | | Lansdowne | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14 FATHER'S NAME | | 15 MOTHER'S MAIDEN NAME | | 13e STREET ADDRESS / ZIP CODE | | | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | 300 4th Avenue, 21227 | | | |
| Sydnor K. Morrison | | Lenora Cook | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | 16b SOCIAL SECURITY NO. | | 17 INFORMANT | | ADDRESS | |
| Yes WWII | | 216-01-4104 | | Bernard Morrison, Jr., | | 704 Woodland Drive | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio Resp Arrest
DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Cancer of Lung
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? | | 20b IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH? | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2) | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21d INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a I certify that (I) (this hospital) attended the deceased from November 28, 1986, to Dec 9, 1986, that (I) (we) last saw the deceased alive on Dec 9, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b SIGNATURE | | | | DEGREE | | 22c DATE SIGNED | |
| John Tygart | | | | MD | | 12/9/86 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e ADDRESS | | | |
| John Tygart | | | | South Baltimore General Hospital | | | |
| 23a BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION
CITY OR TOWN COUNTY STATE | |
| Burial | | 12/12/86 | | Loudon Park Cemetery | | Baltimore Maryland | |
| 24 FUNERAL DIRECTOR
NAME ADDRESS | | | | 25a DATE REC'D. BY REGISTRAR | | 25b REGISTRAR'S SIGNATURE | |
| Hubbard Funeral Home, Inc., 4107 Wilkens Ave. | | | | 21229 DEC 10 1986 | | John Tygart | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completed and returned to the funeral director. The funeral director must completely fill in by the funeral director, page 3 of this certificate. The funeral director must also fill in by the funeral director, page 4 of this certificate. The funeral director must also fill in by the funeral director, page 5 of this certificate. The funeral director must also fill in by the funeral director, page 6 of this certificate. The funeral director must also fill in by the funeral director, page 7 of this certificate. The funeral director must also fill in by the funeral director, page 8 of this certificate. The funeral director must also fill in by the funeral director, page 9 of this certificate. The funeral director must also fill in by the funeral director, page 10 of this certificate. The funeral director must also fill in by the funeral director, page 11 of this certificate. The funeral director must also fill in by the funeral director, page 12 of this certificate. The funeral director must also fill in by the funeral director, page 13 of this certificate. The funeral director must also fill in by the funeral director, page 14 of this certificate. The funeral director must also fill in by the funeral director, page 15 of this certificate. The funeral director must also fill in by the funeral director, page 16 of this certificate. The funeral director must also fill in by the funeral director, page 17 of this certificate. The funeral director must also fill in by the funeral director, page 18 of this certificate. The funeral director must also fill in by the funeral director, page 19 of this certificate. The funeral director must also fill in by the funeral director, page 20 of this certificate. The funeral director must also fill in by the funeral director, page 21 of this certificate. The funeral director must also fill in by the funeral director, page 22 of this certificate. The funeral director must also fill in by the funeral director, page 23 of this certificate. The funeral director must also fill in by the funeral director, page 24 of this certificate. The funeral director must also fill in by the funeral director, page 25 of this certificate. The funeral director must also fill in by the funeral director, page 26 of this certificate. The funeral director must also fill in by the funeral director, page 27 of this certificate. The funeral director must also fill in by the funeral director, page 28 of this certificate. The funeral director must also fill in by the funeral director, page 29 of this certificate. The funeral director must also fill in by the funeral director, page 30 of this certificate. The funeral director must also fill in by the funeral director, page 31 of this certificate. The funeral director must also fill in by the funeral director, page 32 of this certificate. The funeral director must also fill in by the funeral director, page 33 of this certificate. The funeral director must also fill in by the funeral director, page 34 of this certificate. The funeral director must also fill in by the funeral director, page 35 of this certificate. The funeral director must also fill in by the funeral director, page 36 of this certificate. The funeral director must also fill in by the funeral director, page 37 of this certificate. The funeral director must also fill in by the funeral director, page 38 of this certificate. The funeral director must also fill in by the funeral director, page 39 of this certificate. The funeral director must also fill in by the funeral director, page 40 of this certificate. The funeral director must also fill in by the funeral director, page 41 of this certificate. The funeral director must also fill in by the funeral director, page 42 of this certificate. The funeral director must also fill in by the funeral director, page 43 of this certificate. The funeral director must also fill in by the funeral director, page 44 of this certificate. The funeral director must also fill in by the funeral director, page 45 of this certificate. The funeral director must also fill in by the funeral director, page 46 of this certificate. The funeral director must also fill in by the funeral director, page 47 of this certificate. The funeral director must also fill in by the funeral director, page 48 of this certificate. The funeral director must also fill in by the funeral director, page 49 of this certificate. The funeral director must also fill in by the funeral director, page 50 of this certificate. The funeral director must also fill in by the funeral director, page 51 of this certificate. The funeral director must also fill in by the funeral director, page 52 of this certificate. The funeral director must also fill in by the funeral director, page 53 of this certificate. The funeral director must also fill in by the funeral director, page 54 of this certificate. The funeral director must also fill in by the funeral director, page 55 of this certificate. The funeral director must also fill in by the funeral director, page 56 of this certificate. The funeral director must also fill in by the funeral director, page 57 of this certificate. The funeral director must also fill in by the funeral director, page 58 of this certificate. The funeral director must also fill in by the funeral director, page 59 of this certificate. The funeral director must also fill in by the funeral director, page 60 of this certificate. The funeral director must also fill in by the funeral director, page 61 of this certificate. 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The funeral director must also fill in by the funeral director, page 82 of this certificate. The funeral director must also fill in by the funeral director, page 83 of this certificate. The funeral director must also fill in by the funeral director, page 84 of this certificate. The funeral director must also fill in by the funeral director, page 85 of this certificate. The funeral director must also fill in by the funeral director, page 86 of this certificate. The funeral director must also fill in by the funeral director, page 87 of this certificate. The funeral director must also fill in by the funeral director, page 88 of this certificate. The funeral director must also fill in by the funeral director, page 89 of this certificate. The funeral director must also fill in by the funeral director, page 90 of this certificate. The funeral director must also fill in by the funeral director, page 91 of this certificate. The funeral director must also fill in by the funeral director, page 92 of this certificate. The funeral director must also fill in by the funeral director, page 93 of this certificate. The funeral director must also fill in by the funeral director, page 94 of this certificate. The funeral director must also fill in by the funeral director, page 95 of this certificate. The funeral director must also fill in by the funeral director, page 96 of this certificate. The funeral director must also fill in by the funeral director, page 97 of this certificate. The funeral director must also fill in by the funeral director, page 98 of this certificate. The funeral director must also fill in by the funeral director, page 99 of this certificate. The funeral director must also fill in by the funeral director, page 100 of this certificate.

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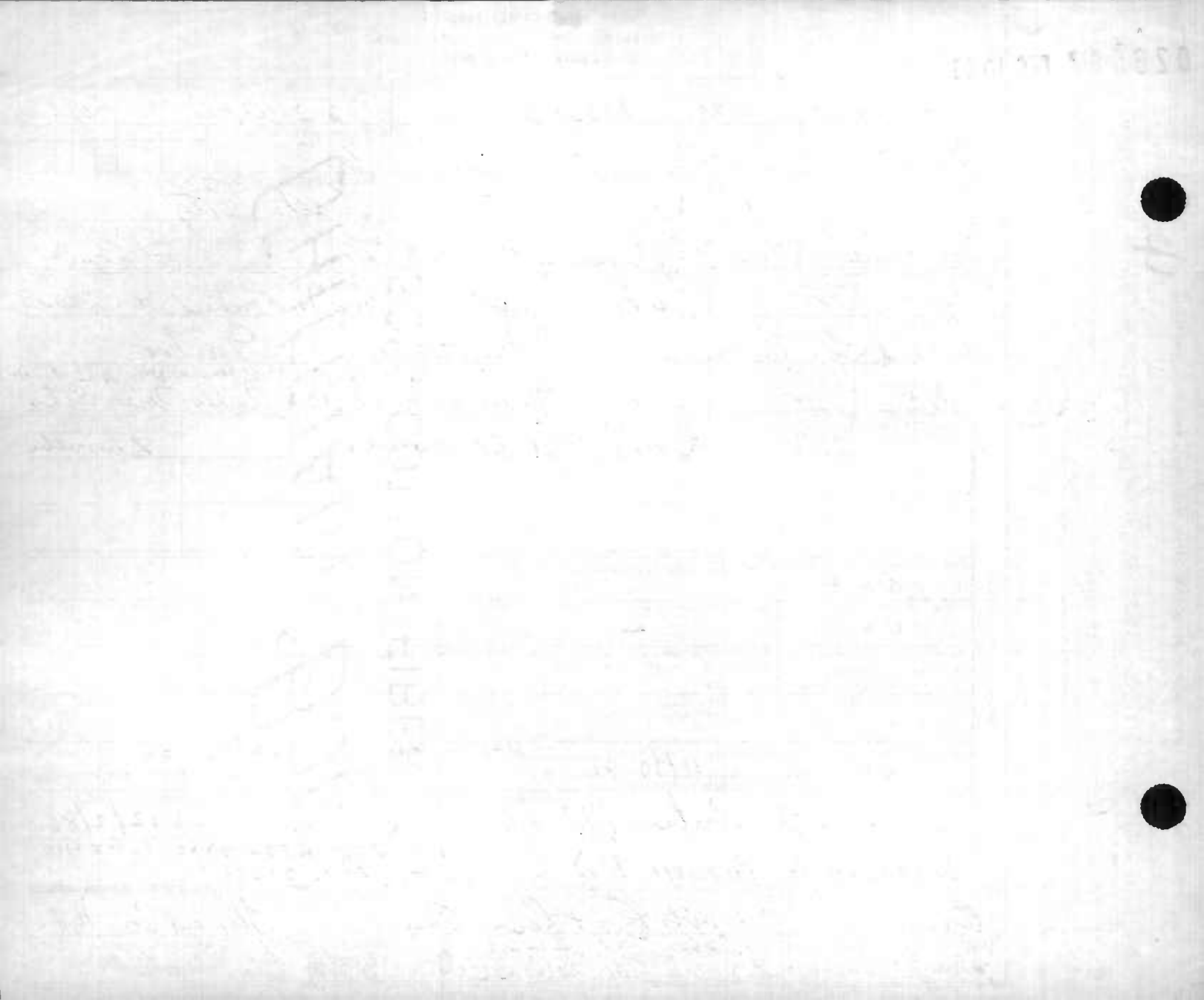
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|--|---|--|--|--|---|--|
| FOR
STATE
REGISTRAR | | | | | REG. NO. | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT)
ALICE M. MOSES | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12-2-1986 | | | 2b. HOUR
5:00 A.M. | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
7-1-1921 | | 6. AGE (IN YEARS LAST BIRTHDAY)
65 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Ind. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
1106 W. Lombard St. 21223 | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
at home | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13. STATE Ind. | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS & ZIP CODE
1106 W. Lombard St. 21223 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Howard H. Beeman | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Therese Garlotz | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
- | | 17. INFORMANT
Wayne R. Moses Box 5 Address 1122 Fisher Ferry Crt. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Renal cell carcinoma | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
8 months | |
| DUE TO, OR AS A CONSEQUENCE OF
(b) | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a
None | | | | | | | | | |
| 19a. DATE OF OPERATION
N/A | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
- | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK
NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from MAY 19 86, to 12/2 19 86, that (I) (we) last saw the deceased alive on 11/30 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Norman A. Poulsen MD | | | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12/2/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
NORMAN A. POULSEN MD | | | | 22e. ADDRESS
419 WEST REDWOOD ST SUITE 410
BALT., MD. 21201 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(Type) | | 23b. DATE
12-6-1986 | | 23c. NAME OF CEMETERY OR CREMATORY
Great Lawn Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Howard Co. Ind. | | | |
| 24. FUNERAL DIRECTOR
NAME
John J. Cowan & Son Inc. 901 Hollins St. | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 05 1986 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | | |

050000 100000



026356 DEC-1985

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 3 4 7 6 3

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
DOMINIK MOSZUMANSKI | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 1 86 | | | 2b. HOUR
10 ⁰⁵ AM | |
| 3. SEX
M | | 4. RACE
Cauc | | 5. DATE OF BIRTH
MONTH DAY YEAR
11-5-13 | | 6. AGE (IN YEARS LAST BIRTHDAY)
72 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
Balto. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
827 S. Kenwood Ave. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Miner | | 12b. KIND OF BUSINESS OR INDUSTRY
Coal | |
| 13a. STATE
Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN
Balto. | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | 13e. STREET ADDRESS / ZIP CODE
827 S. Kenwood Ave. 21224 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Unkn | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
213-34-7594 | | 17. INFORMANT ADDRESS | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio-pulmonary Arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) Squamous cell CA of lung.
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11c | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/1, 19 86, to 12/1, 19 86, that (I) (we) lost
saw the deceased alive on 12/1, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Lea Stern | | DEGREE
MD | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
12/1/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
LEA STERN | | 22e. ADDRESS
4940 Eastern Ave Baltimore MD 21224 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Removal | | 23b. DATE
12-3-86 | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | |
| 24. FUNERAL DIRECTOR
NAME
Anatomy Board | | ADDRESS
Balto., Md. | | 25. DATE REC'D. BY REGISTRAR
DEC 04 1986 | | 25. REGISTRAR'S SIGNATURE
Julia Anderson-Randall | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked on item 18 above any injury, or other traumatic event, the medical examiner must be notified at once.

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DEC 04 1988

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the medical examiner and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Department of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | REG. NO. | | | | | |
|---|--|---|--|---|--|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
EUGENE B. MOSS Jr. | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
12-31-86 | | | | 2b. HOUR
7:50 P^M | |
| 3. SEX
Male | | 4. RACE
Black | | 5. DATE OF BIRTH MONTH DAY YEAR
29 24 | | 6. AGE (IN YEARS LAST BIRTHDAY)
62 | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Mercy Hospital | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
INDUSTRY | | 12b. KIND OF BUSINESS OR INDUSTRY
Beth. Steel | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md. | | | | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Eugene B. MOSS Sr. | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Dorothy Lacks | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
226-24-9612 | | 17. INFORMANT ADDRESS
Eyron Moss 515 Maine St | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) METASTATIC LYMPHOID CYTIC LEUKEMIA
DUE TO, OR AS A CONSEQUENCE OF (b) GRAM NEGATIVE SEPSIS
DUE TO, OR AS A CONSEQUENCE OF (c) ANEMIA / THROMBOCYTOPENIA | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
17 years
1 week
2 months | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: no | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/27 19 86 , to 12/31 19 86 , that (I) (we) last saw the deceased alive on 12-31 19 86 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. PHYSICIAN'S SIGNATURE
C S NESBITT MD | | | | | | DEGREE
MD | | 22c. DATE SIGNED
12/31/86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
C S NESBITT | | | | | | 22e. ADDRESS
301 ST ANNE ST BALT, MD 21201 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
1/6/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Lack Family Cemetery | | 23d. LOCATION
Chatham County, Cover Virginia | | | |
| 24. FUNERAL DIRECTOR
NAME
Wm. C. March F/H 1101 E North Ave. | | | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 2 1987 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randee | | |



028194 DE 29 1986

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|---------|---|--------|---|-------------------|---|-----|--------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | MONTH | DAY | YEAR | 2b. HOUR |
| Benjamin | | A. | | Mrozinski | December | 16, | | 1986 | M |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 74 HRS. | |
| Male | White | April 18 1905 | | 81 | | MONTHS | | DAYS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Md. | | USA | | | | Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Baltimore | | 627 S. Kenwood Ave. | | Conductor | | Railroad | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS / ZIP CODE | |
| Md. | | | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 627 S. Kenwood Ave. 21224 | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | | | | | | |
| Casimir | | Mrozinski | | Pauline Gromacka | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES) | | 17. INFORMANT ADDRESS | | | | | |
| No | | 717-07-8367 | | Robert Mrozinski 2611 Ivy Pl. 21234 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>metastatic colon cancer</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 21g. I certify that (I) (this hospital) attended the deceased from <u>7/26/86</u> , 19_____, that (I) (we) last saw the deceased alive on <u>7/26/86</u> , 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22a. SIGNATURE | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | | | |
| Victoria Vanik MD | | | | | | 12/17/86 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | |
| VICTORIA VANIK | | Albert Witke Medical Center | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | COUNTY STATE | |
| Burial | | 12-20-1986 | | Holy Rosary Cemetery | | Baltimore | | Md. | |
| 24. FUNERAL DIRECTOR | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| NAME ADDRESS
JOHN M. WEBER & SONS INC. 401 S. CHESTER ST.. | | | | DEC 23 1986 | | John Sinden-Rodgers | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-permit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified on page 4.

8 5 3 4 7 6 5



8 6 3 4 1 0 0

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 must be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| | | | | | | | | | | | | | | | |
|--|--|---|--|---|--|---|--|-----------------|--|-----------------|--|------|--|------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | MIDDLE | | LAST | | 2a. DATE OF DEATH | | MONTH | | DAY | | YEAR | | 2b. HOUR | |
| JOSEPH | | G. | | MUELLER, Sr. | | DECEMBER 17, 1986 | | | | | | | | 11:15A | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS (LAST BIRTHDAY)) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | | | | |
| Male | | White | | 11-18-1916 | | 70 | | YRS | | MONTHS | | DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | |
| Balto., MD | | USA | | | | BALTIMORE CITY | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | |
| BALTIMORE City | | THE JOHNS HOPKINS HOSPITAL | | Fork Lift Driver | | Sears | | | | | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. CITY OR TOWN | | 13c. STREET ADDRESS / ZIP CODE | | | | | | | | | | | |
| MD | | Balto. | | 8007 Gough St., Balto. 21224 | | | | | | | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | |
| Charles | | Theresa | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES) | | 17. INFORMANT | | ADDRESS | | | | | | | | | |
| Yes | | Army WW II | | Margaret T. Mueller | | 8007 Gough St. 21224 | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Sepsis</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>(R) BASAL GANGLIA HEMORRHAGE</u> | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
<u>5 MIN</u>
<u>36 HOURS</u>
<u>20 DAYS</u> | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<u>RENAL FAILURE</u> | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| 22a. I certify that (I) [this hospital] attended the deceased from <u>NOV 28</u> , 19 <u>86</u> , to <u>DEC. 17</u> , 19 <u>86</u> , that (I) (we) lost
saw the deceased alive on <u>DEC. 17</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
<u>David Brown</u> | | DEGREE
<u>MD</u> | | 22c. DATE SIGNED
<u>12/17/86</u> | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>DAVID BROWN</u> | | 22e. ADDRESS
<u>JOHNS HOPKINS HOSPITAL, BALTO., MD.</u> | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
<u>Burial</u> | | 23b. DATE
<u>12-20-86</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Holy Redeemer</u> | | 23d. LOCATION
BALTO. City COUNTY M,D STATE | | | | | | | | | |
| 24. FUNERAL DIRECTOR
(NAME)
<u>John C. Miller, Inc., 6415 Belair Rd. 21206</u> | | 25a. DATE REC'D. BY REGISTRAR
<u>DEC 19 1986</u> | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | | | | | | | | | | | |

25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

Handwritten notes and diagrams, including a large rectangular box with internal lines and various markings.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | |
|---|---|--|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT) John G MURRMANN | | 2b. DATE OF DEATH MONTH DAY YEAR 12/8/86 | | 2b. HOUR 10.55 PM |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 1/28/05 | 6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS. | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Germany | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Good Samaritan Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Baker | 12b. KIND OF BUSINESS OR INDUSTRY Baker | |
| 13a. STATE MARYLAND | 13b. CITY OR TOWN BALTIMORE | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13d. STREET ADDRESS / ZIP CODE 610 Streeper Street - 21205 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Theresa C. Murrmann | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | 16b. SOCIAL SECURITY NO. 216-01-1328 | 17. INFORMANT ADDRESS Theresa C. Murrmann, 610 N. Streeper St. 21205 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Sudden Death
DUE TO, OR AS A CONSEQUENCE OF (b) Congestive Heart Failure
DUE TO, OR AS A CONSEQUENCE OF (c) Bleeding Duodenal Uler.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Stroke | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 11/14/86 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/14/86 to 12/9/86 , that (I) (we) last saw the deceased alive on 12/9/86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | |
| 22b. SIGNATURE Michael Chait | DEGREE MD | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED 12/9/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael Chait | | 22e. ADDRESS Good Samaritan, 5601 Loch Raven, Balt MD. | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 12-12-86 | 23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery | 23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Balto., MD | |
| 24. FUNERAL DIRECTOR NAME John C. Miller, Inc., 6415 Belair Rd. 21206 | | 25a. DATE REC'D. BY REGISTRAR DEC 12 1986 | 25b. REGISTRAR'S SIGNATURE Lelia Henderson-Randall | |

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1811/12/12

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | | |
|--|--|---------|-------------------|--|--|-------------------|--|---|--|------------------|--|--|--|----------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a. DATE OF DEATH | | | KNOWN ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR | | | 2b. HOUR | | | |
| Mrytle | | | May | | | Myers | | | 11/ 13/19 86 | | | M | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | 7d. HOUR | |
| Female | | Black | | 7/20/00 | | 86 YRS. | | MONTHS DAYS | | HOURS MIN. | | 11/ 13/19 86 | | 5:15 P M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Md. | | | | USA | | | | | | | | Baltimore City, MD. | | | |
| 11. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Baltimore | | | | 2713 Cylburn Ave. | | | | | | | | | | | |
| 13a. STATE | | | | 13b. COUNTY | | | | 13c. CITY OR TOWN | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| Md. | | | | | | | | Baltimore | | | | 2713 Cylburn Ave. 21215 | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | |
| FIRST MIDDLE LAST | | | | FIRST MIDDLE LAST | | | | | | | | | | | |
| George | | | | Cooper | | | | Ola | | | | Cooper | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT | | | | ADDRESS | | | |
| No | | | | 217-22-5273 | | | | Myrtle Gonzalez | | | | 1840 Eagler St. 21223 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>Margarita A. Korell</u> | | | | TITLE (SPECIFY)
M.D. Assistant | | | | MEDICAL EXAMINER | | | | DATE SIGNED 11/14/86 | | | |
| EXAMINER'S NAME
(TYPE OR PRINT) | | | | ADDRESS | | | | | | | | | | | |
| Margarita A. Korell, M.D. | | | | 111 Penn St. | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | |
| Burial | | | | 11/20/86 | | | | Mt. Auburn Cem. | | | | Westport Md. | | | |
| 24. FUNERAL DIRECTOR
NAME | | | | ADDRESS | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | |
| Chas. A. Rice | | | | FSPA 1300 Eutaw Place | | | | NOV 21 1986 | | | | Julia Davidson-Randall | | | |

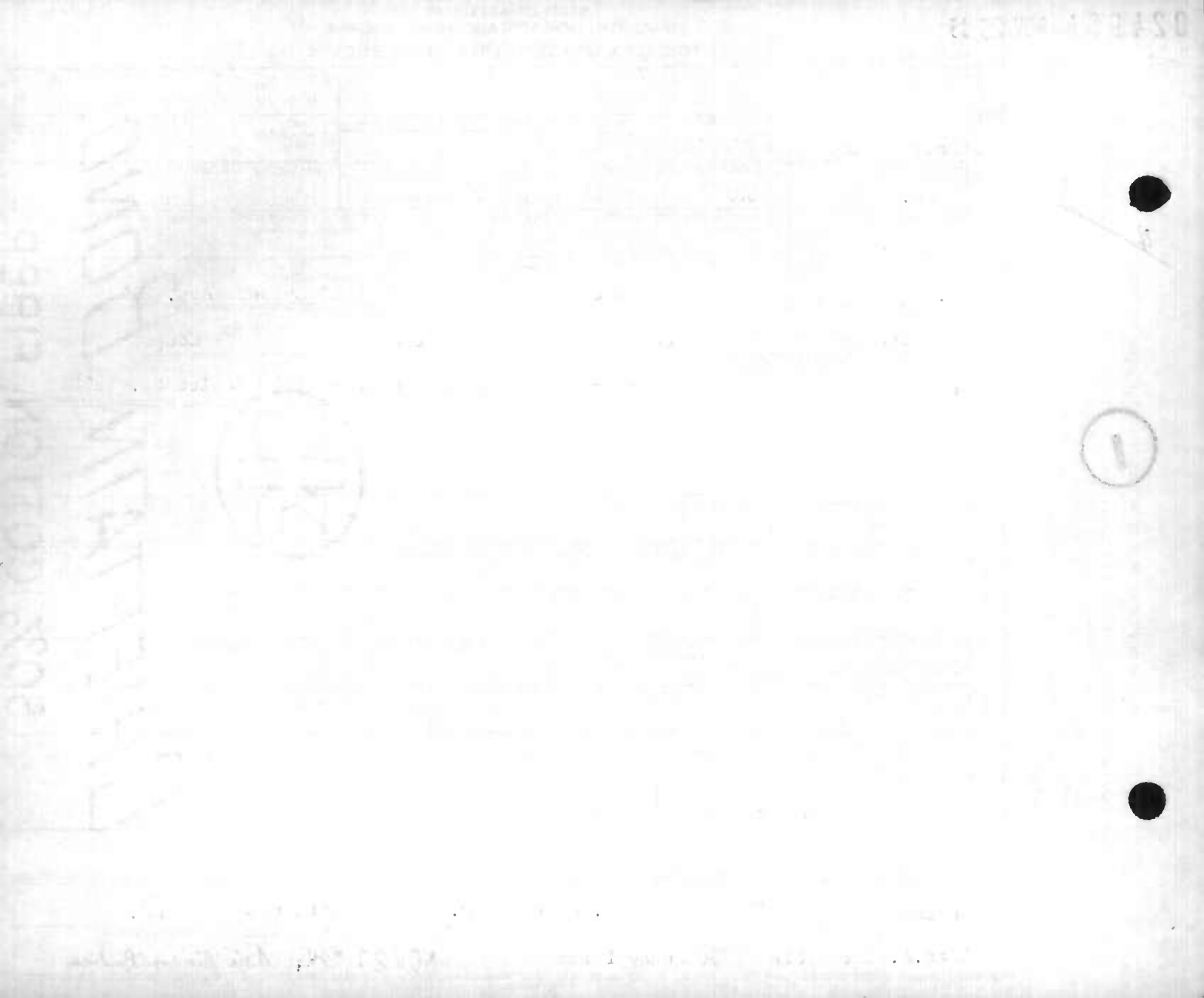
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 1 AND 2 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT (PAGES) AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))



026445 DEC

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|--|--|--|--|--|
| 1- FOR STATE REGISTRAR
Edward Navratil | | 2a. DATE OF DEATH
12-4-86 | | 2b. HOUR
5:40 PM | |
| 1- DECEASED NAME
(TYPE OR PRINT)
EDWARD NAVRATIL | | 3 SEX
MALE | | 4 RACE
CAUCASIAN | |
| 5. DATE OF BIRTH
MONTH DAY YEAR
1 7 21 | | 6 AGE (IN YEARS LAST BIRTHDAY)
65 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10 CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Francis Scott Key Med.Cntr | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD. | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
unemployed | | 12b. KIND OF BUSINESS OR INDUSTRY
-- | | 13a. STATE
Maryland | |
| 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS / ZIP CODE
28 S. Patterson Pk. Ave, 21231 | | 14. FATHER'S NAME
FIRST MIDDLE LAST
Edward J. Navratil | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Julia H. Preborska | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
WWII
219-01-5864 | | 17. INFORMANT
ADDRESS
Phoenix, Md. 21131
Veronica Griffith, Niece, 1 Glen Alpine Rd | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>MYOCARDIAL INFARCTION</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>ATHEROSCLEROTIC HEART DISEASE</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>40 MIN</u>
<u>50 MIN</u>
<u>2 YEARS</u> | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u> | |
| 19a. DATE OF OPERATION
<u>12-4-86</u> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
<u>CAROTID ARTERY STENOSIS</u> | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER)
P.M.
19 | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M.
19 | |
| 21c. HOW INJURY OCCURRED
(ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | |
| 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | 22a. certify that (1) (this hospital) attended the deceased from <u>12-1</u> 19 <u>86</u> , to <u>12-4</u> 19 <u>86</u> that (1) I saw the deceased alive on <u>12-4</u> 19 <u>86</u> and that in my (1) opinion death occurred on the date and hour and from the causes stated above (1) I saw (1) I did not view the body after death. | | 22b. SIGNATURE
<u>Samuel J. Hassenbusch, M.D.</u>
DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | |
| 22c. DATE SIGNED
<u>12-4-86</u> | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>SAMUEL J. HASSENBUSCH</u> | | 22e. ADDRESS
<u>F.S. KEY HOSPITAL, BALTO, MD.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
<u>Burial</u> | | 23b. DATE
<u>12/9/86</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Holy Redeemer</u> | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
<u>Baltimore, Md.</u> | | 24 FUNERAL DIRECTOR
NAME
<u>SCHIMUNEK FUNERAL HOME, Balto, Md. 21213</u> | | 25a. DATE REC'D. BY REGISTRAR
<u>DEC 8 1986</u> | |
| 25b. REGISTRAR'S SIGNATURE
<u>...</u> | | 25c. REGISTRAR'S SIGNATURE
<u>...</u> | | 25d. REGISTRAR'S SIGNATURE
<u>...</u> | |

MEDICAL CERTIFICATION

29

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be filed with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and file them with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the attending physician must be notified of once.

BP

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027664 DEC 19 1986

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 3 4 7 7 0

REG. NO.

| | | | | | | |
|---|--|---|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
LOIS Jean NELSON | | | 2a. DATE OF DEATH
MONTH DAY YEAR
DECEMBER 16, 1986 | | 2b. HOUR
A
3:23 M | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
OCT. 18, 1967 | | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 6. AGE (IN YEARS LAST BIRTHDAY)
19
YRS | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE JOHNS HOPKINS HOSPITAL | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD | | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Salesperson | | 12b. KIND OF BUSINESS OR INDUSTRY
Dept. Store | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Wayne Arnold Nelson | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Rita Delaine Thompson | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
217-96-3445 | | 17. INFORMANT
ADDRESS
R. Delaine Thompson, 2211 Fleetwood Ave. 21214 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiac arrest</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>hypotension</u>
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>10 minutes</u>
<u>15 minutes</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a
<u>leukemia, aplasia pericardial effusion hyperammoneia</u> | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (1) (this hospital attended the deceased from <u>11-2</u> 19 <u>86</u> to <u>12-16</u> 19 <u>86</u> , that (1) (we) lost saw the deceased alive on <u>12-16</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
<u>Frederick M. Gessner MD</u> | | DEGREE
MD | | 22c. DATE SIGNED
12-16-86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>Frederick M. Gessner MD</u> | | 22e. ADDRESS
<u>600 N Wolfe St Balto Md 21205</u> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Dec. 19, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY
Moreland Mem. Pk. | | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Parkville, Balto., Md. | | 24. FUNERAL DIRECTOR
ROBERT C. ALTENBURG FUNERAL HOME, INC.
6009 Harford Rd., Balto., Md. 21214 | | 25a. DATE REC'D. BY REGISTRAR
DEC 17 1986 | | |
| 25b. REGISTRAR'S SIGNATURE
<u>Julia [Signature]</u> | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

CP 50 101 E
C 4000 101 E
C 4000 101 E

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then detach and send to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of case.

DHMH - 16 60M 7/84
(VRA 15, 4)

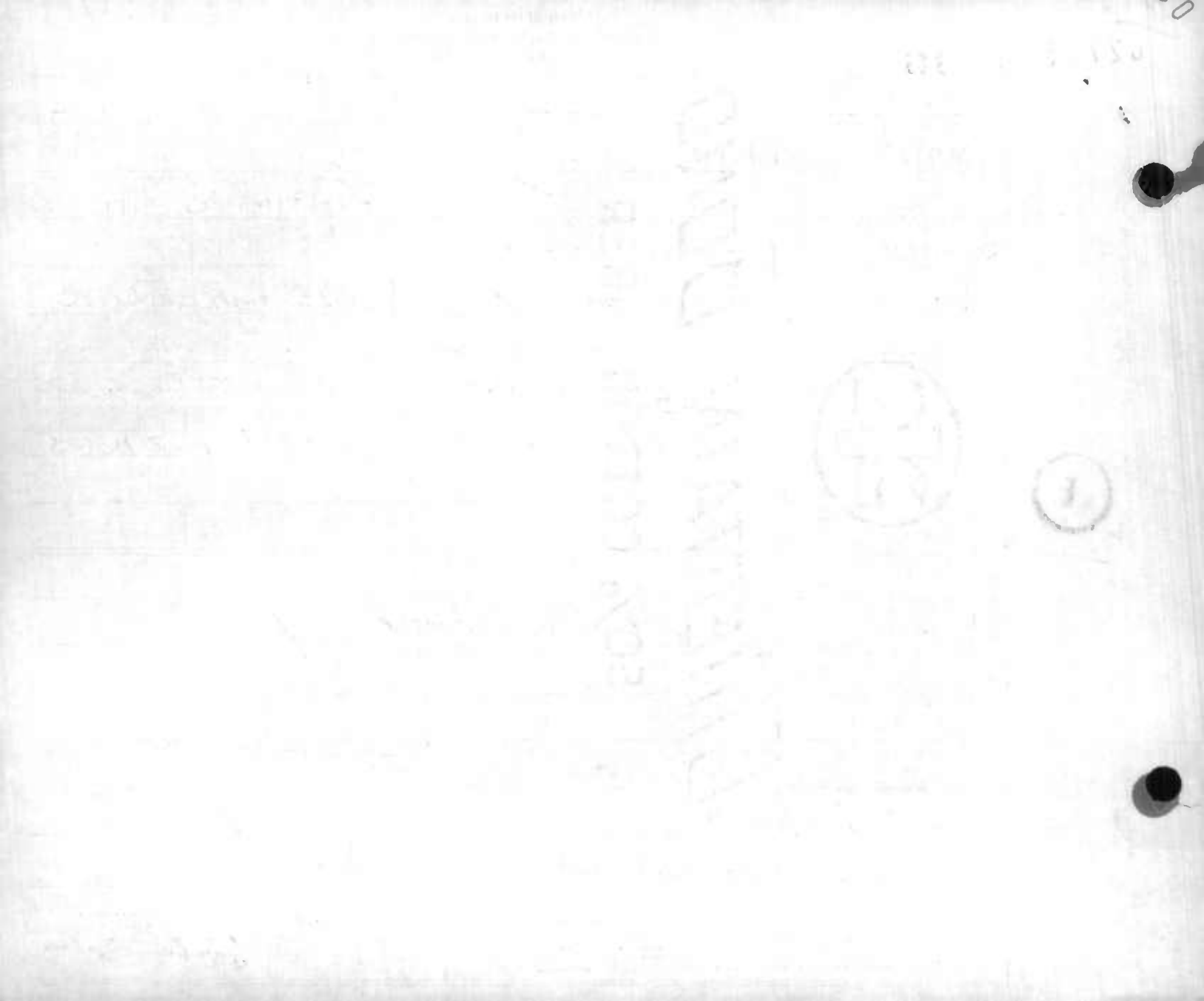
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
RECORDS
DEC 19 1986

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
SELIG
NEUFELD | | MIDDLE
XXXXXX | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 15 86 | | 2b. HOUR
11:10A.M. | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
5 10 10 | | 6. AGE (IN YEARS LAST BIRTHDAY)
76 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
POLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore city MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Sinai HOSPITAL | | 12a. USUAL OCCUPATION
(IF NOT MOST OF WORKING LIFE)
GROCER | | 12b. KIND OF BUSINESS OR
FOOD | |
| 13a. STATE
Maryland | | | | 13b. COUNTY | | 13c. CITY OR TOWN | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
LEON NEUFELD | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ROSE H. GOLD | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, GIVE WAR OR DATES)
NO | | 16b. SOCIAL SECURITY NO.
08526 1887 | | 17. INFORMANT
ADDRESS
MRS. MARIE NEUFELD 6023 HIGHGATE DR. 21215 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c).
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(c) _____
DUE TO, OR AS A CONSEQUENCE OF
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>2 hours</u> | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 1a | | | | | | | |
| 19a. DATE OF OPERATION
11/11 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Peripheral Vascular disease | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/5</u> 19 <u>86</u> to <u>12/15</u> 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>12/15</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Gloria C Johnson MD | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)
Gloria C Johnson MD | | 22e. ADDRESS
Sinai Hospital | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
12/16/86 | | 23c. NAME OF CEMETERY OR CREMATORY
BETH TFILOH CEM | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE MARYLAND | |
| 24. FUNERAL DIRECTOR
SOL LEVINSON & BROS., INC.
6010 REISTERSTOWN RD. BALTO, MD 21215 | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 19 1986 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | | | | | |
|---|--|---|--|--|---|---|--------------------------------|--|------------------|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | | MONTH | DAY | YEAR | 2b. HOUR | |
| Sophia E. NEVAKER | | | | | 12/20/86 | | | | | 2:35 PM | |
| 3. SEX | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | |
| Female | White | | Mar. 1 95 | | 91 YRS. | | MONTHS | | DAYS | | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | |
| Maryland | USA | | | | Baltimore City | | | | MD. | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | |
| BALTIMORE | UNIV OF MARYLAND HOSP | | Sales Lady | | Ben Franklin | | | | | | |
| 13a. STATE | | 13b. COUNTY | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS / ZIP CODE | | | | |
| Maryland | | --- | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 1242 Carroll Street, 21230 | | | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | |
| FIRST MIDDLE LAST | | | FIRST MIDDLE LAST | | | | | | | | |
| Henry Frage | | | Elizabeth Glanzer | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | |
| No | | 216-40-1619 | | Doris M. Hayden | | 403 Sherwood Road, 21036 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | | |
| (b) <u>Pulmonary edema</u> | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) <u>Coronary artery disease</u> | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | |
| | | P.M. 19 | | | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | | CITY OR TOWN | | COUNTY | | STATE | |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | STREET | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the decedent from <u>12/18</u> , 19 <u>86</u> , to <u>12/20</u> , 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>12/20</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | | | 22c. DATE SIGNED | | | | | |
| <u>Thuy V. Nguyen</u> | | | | | | 12/20/86 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | | | | |
| THUY NGUYEN | | Univ of Maryland Hosp | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | CITY OR TOWN | | COUNTY STATE | |
| Burial | | 12/23/86 | | Loudon Park Cemetery | | Baltimore | | | | Maryland | |
| 24. FUNERAL DIRECTOR | | NAME | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Hubbard Funeral Home, Inc., | | 21229 | | 4107 Wilkens Ave. | | DEC 22 1986 | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 and file them within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or other final disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove car-bol tags and return them to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DHMH - 16 60M 7/84
(VRA 15, 4)STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | |
|---|--|---|--|---|--|---|--|--|---|--|--|-------------------------------------|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) EVA | | | 2a. DATE OF DEATH
MONTH 12 DAY 29 YEAR 86 | | | 2b. HOUR
11:50 AM | | | | | | | | |
| 3. SEX
F | | 4. RACE
B | | 5. DATE OF BIRTH
MONTH 03 DAY 06 YEAR 04 | | | 6. AGE (IN YEARS LAST BIRTHDAY)
82 YRS. | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
N. CAROLINA | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTO. CITY MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH
BALTO | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Bow Secours Hosp. | | | 12a. USUAL OCCUPATION
(TYPE OF WORK, FOR MOST OF WORKING LIFE)
SEAMSTRESS | | | 12b. KIND OF BUSINESS OR INDUSTRY
- | | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
STATE Baltimore | | | 13b. COUNTY
Maryland | | | 13c. CITY OR TOWN
Maryland | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 14. FATHER'S NAME
FIRST James MIDDLE B. LAST BLAND | | | 15. MOTHER'S MAIDEN NAME
FIRST Isabella MIDDLE Walker LAST Walker | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO.
220-64-4226 | | | | | |
| 17. INFORMANT
NAME Maggie B. James ADDRESS 3408 W. Mulberry St. | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Severe Renal Insufficiency
DUE TO, OR AS A CONSEQUENCE OF (b) Infected Decubitus Wound
DUE TO, OR AS A CONSEQUENCE OF (c) ASCVD & CHF | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
29 | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: - | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12-19-86 to 12-29-86 , that (I) (we) lost saw the deceased alive on 12-28-86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | 22b. SIGNATURE
A.I. BAYKALER, MD | | | 22c. DATE SIGNED
12-29-86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
A.I. BAYKALER | | | 22e. ADDRESS
831 Poplar Grove St - Bal. | | | 22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
1/3/87 | | | 23c. NAME OF CEMETERY OR CREMATORY
King Mem. Pk. | | | 23d. LOCATION
CITY OR TOWN Randelstown COUNTY Md. STATE | | | | | |
| 24. FUNERAL DIRECTOR
NAME W.C. March F.H. ADDRESS 4300 Wabash Ave. | | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 31 1986 | | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | | | | |

029547 JAN 12

17 FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|--|--|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST <i>Anna</i> MIDDLE LAST <i>Newman</i> | | | 2a. DATE OF DEATH
MONTH <i>12</i> DAY <i>25</i> YEAR <i>86</i> | | 2b. HOUR
<i>3:50</i> AM |
| 3. SEX
<i>Female</i> | 4. RACE
<i>Caucasian</i> | 5. DATE OF BIRTH
MONTH <i>12</i> DAY <i>14</i> YEAR <i>17</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>69</i> YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
<i>Maryland</i> | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Baltimore City</i> MD. | |
| 10. CITY OR TOWN OF DEATH
<i>Baltimore</i> | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Bon Secours Hospital</i> | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>unemployed</i> | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
<i>Maryland</i> | | 13b. COUNTY
<i>Baltimore</i> | 13c. CITY OR TOWN
<i>Baltimore</i> | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) <i>NO</i> | | 16b. SOCIAL SECURITY NO.
<i>220-18-7266</i> | | 17. INFORMANT
ADDRESS
<i>Fr. Robert M. Kearma</i> | |

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) *Myocardial Infarction*

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.(b) *coronary atherosclerosis*

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHPART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Chronic Obstructive Lung Disease

| | | | |
|---|--|--|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>6</i> , 19 <i>82</i> , to <i>12/24</i> , 19 <i>86</i> , that (I) (we) last
saw the deceased alive on <i>12/24</i> , 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
<i>M. Keenan</i> | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<i>12/25/86</i> |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>M. Keenan</i> | 22e. ADDRESS
<i>2717-HAMMOND FRANK RD BALDOR</i> | | |

| | | | |
|--|----------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<i>Burial</i> | 23b. DATE
<i>1/5/87</i> | 23c. NAME OF CEMETERY OR CREMATORY
<i>New Cathedral Cem.</i> | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Baltimore, Md.</i> |
| 24. FUNERAL DIRECTOR
NAME
<i>Charles A. Rice FSPA 1300 Eutaw Pl,</i> | | 25a. DATE RECEIVED BY REGISTRAR
<i>JAN 8 1987</i> | |
| | | 25b. REGISTRAR'S SIGNATURE
<i>Julian [Signature]</i> | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been given by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then place this certificate in the burial-transit permit, and return it to the funeral director with the State Dept. of Health and Mental Hygiene permit, burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, another traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, a medical examiner shall be called to the place of death.

027454 DEC 17 1986

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

12-14-86

FOR
STATE
REGISTRAR

| | | | | | | | |
|--|--|---|--|---|----------------------------|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Helen A. Noeth | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12-14-86 | | 2b. HOUR
555P M. | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
2 26 07 | | 6. AGE (IN YEARS LAST BIRTHDAY)
79 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
CITY MD. | |
| 10. CITY OR TOWN OF DEATH
Balto. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
North Charles General Hosp. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Ret. Operator | |
| 12b. KIND OF BUSINESS OR INDUSTRY
C&P | | | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md. | | 13b. COUNTY
Balto. | | 13c. CITY OR TOWN
Balto. | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Anthony Wasel | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Alice Brinkhavic | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No | | | |
| 16b. SOCIAL SECURITY NO.
212-10-0017 A | | 17. INFORMANT ADDRESS
Roberta Huesman, Same as 13e | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) advanced atherosclerosis Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) with cardiac arrhythmia (CUT)
DUE TO, OR AS A CONSEQUENCE OF
(c) with cardio-pulmonary arrest
DUE TO, OR AS A CONSEQUENCE OF | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Diabetic mellitus. Hypertensive cardio vascular diseases. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/27/86 to 12/14/86 , that (I) (we) last saw the deceased alive on 12/14/86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
R.M. Shah M.D. | | | | DEGREE | | 22c. DATE SIGNED
12/14/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
R.M. SHAH, M.D. | | | | 22e. ADDRESS
NORTH CHARLES GENERAL HOSPITAL
BALTIMORE, MD. 21218 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
12-17-86 | | 23c. NAME OF CEMETERY OR CREMATORY
Holy Redeemer | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto., Md. | |
| 24. FUNERAL DIRECTOR
NAME
Leonard J. Ruck, Inc., 5305 Harford Rd. | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 16 1986 | | 25b. REGISTRAR'S SIGNATURE
... | |

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Ethel M. Nolan | | | 2a. DATE OF DEATH
MONTH 12 DAY 19 YEAR 86 | | | 2b. HOUR
4:00 P.M. | |
| 3. SEX
F | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH 12 DAY 25 YEAR 28 | | 6. AGE
YEARS LAST BIRTHDAY 58 YRS. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY) MD | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) retired | |
| 13a. STATE MD | | | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Belvedere at Greenspring | |

| | | | |
|--|--|--|--|
| 14. FATHER'S NAME
FIRST Louis MIDDLE Nolan LAST Nolan | | 15. MOTHER'S MAIDEN NAME
FIRST Bernice MIDDLE E. LAST Campbell | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO.
212-56-0336 | |
| 17. INFORMANT
Helen Nolan | | ADDRESS
3413 Springdale Ave. | |

| | | |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac arrest
DUE TO, OR AS A CONSEQUENCE OF Renal
(b) Respiratory Failure
DUE TO, OR AS A CONSEQUENCE OF Respiratory Failure / CVA / cardiomyopathy
(c) Respiratory Failure / CVA / cardiomyopathy | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1b. | | |

MEDICAL CERTIFICATION

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/1/83 19 86 , to 12/19 19 86 , that (I) (we) last saw the deceased alive on 12/19 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Natalie Brookins-Reddix | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
12/19/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Natalie Brookins-Reddix MD | | | | 22e. ADDRESS
Sinai Hospital / Belvedere at Greenspring | | | |

| | | | | | | | |
|---|--|------------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) Burial | | 23b. DATE
12/26/86 | | 23c. NAME OF CEMETERY OR CREMATORY
Eastview Mem. Pk. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Dundalk, Md. | |
| 24. FUNERAL DIRECTOR
NAME Wm C March F/H West ADDRESS 4300 Wabash Ave. | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 30 1986 | | 25b. REGISTRAR'S SIGNATURE
Julia Tidman-Randall | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the top papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

105-10-1-10550



105-10-1-10550

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item 13E
FOR 1-5-87 A.K.
STATE REGISTRAR per phone

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
NATHAN NOLE | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 30 86 | | 2b. HOUR
7:52 A.M. | |
| 3. SEX
male | 4. RACE
Negro | 5. DATE OF BIRTH
MONTH DAY YEAR
3-18-18 | | 6. AGE (IN YEARS LAST BIRTHDAY)
68
YRS. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
S.C. | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE City MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE CITY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNION MEMORIAL HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
LABOR | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13b. STATE
M.D. | | 13c. CITY OR TOWN
BALTO | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Nathan Nole SR. | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Annie Woodard. | | 16. STREET ADDRESS / ZIP CODE
1623 Bradford 21213 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
W.W.II 274-20-4954 | | 17. INFORMANT
ADDRESS
Susan B. Wright-1623 Bradford #21213 st | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Arrest.
DUE TO, OR AS A CONSEQUENCE OF
(b) Restrictive Cardiomyopathy
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
DUE TO, OR AS A CONSEQUENCE OF
(c) Possible Cardiac Amyloidosis | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 years
3 years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHERE <input type="checkbox"/> HOME <input type="checkbox"/> NEAR HOME <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12-11, 1986, to 12-30, 1986, that (I) (we) last saw the deceased alive on 12-29, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Joseph Raduazzo | | DEGREE
MD
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
12-30-86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JOSEPH RADUAZZO, M.D. | | 22e. ADDRESS
UNION MEMORIAL HOSPITAL | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(CHECK ONE) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY
Westly AME Ch. | |
| | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Shukerville S.C. | |
| 24. FUNERAL DIRECTOR
NAME
Beth Funeral 1129 W. Caroline st. | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR
DEC 01 1986 | |
| | | | | 25b. REGISTRAR'S SIGNATURE | |

026937 DEC 12 1986

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please detach the certificate and return it to the State Dept. of Health and Mental Hygiene with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|--|--|--|--|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
George Albert NORRIS, JR. | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 9 86 | | | | 2b. HOUR
6:20A.M. | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
3 17 1900 | | 6. AGE (IN YEARS LAST BIRTHDAY)
86 YRS | | 7. IF UNDER 1 YEAR
MONTHS DAYS | | 7b. IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
4021 Wilkens Avenue | | | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Pipe Fitter | | 12b. KIND OF BUSINESS OR INDUSTRY
Plumbing | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | | | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
George A. Norris, Sr. | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Annie Felger | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | | | 16b. SOCIAL SECURITY NO.
WW I 705-07-1666 | | 17. INFORMANT
ADDRESS
Marie H. Norris 4021 Wilkens Ave. 21229 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Pneumonia</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic lymphatic leukemia</u>
DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 days
20 years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from _____, 19 <u>86</u> , to <u>Dec 8</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>Nov 13</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (we) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Sueen C. Kravitz, M.D.</u> | | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12/9/86 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Dr. Kravitz | | | | | | 22e. ADDRESS
Union Memorial Hospital | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | 23b. DATE
12/12/86 | | 23c. NAME OF CEMETERY OR CREMATORY
Meadowridge Memorial | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Pk. Elkridge Howard Md. | | | |
| 24. FUNERAL DIRECTOR
NAME
Hubbard Funeral Home, Inc., | | | | | | 24b. ADDRESS
21229 4107 Wilkens Ave. | | 25a. DATE REC'D. BY REGISTRAR
DEC 10 1986 | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | |

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 34779

REG. NO.

| | | | | | | |
|---|---|---|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Nellis Morris | | | 2a. DATE OF DEATH MONTH DAY YEAR
12/27/1986 | | 2b. HOUR
1156A M | |
| 3. SEX
F | 4. RACE
B | 5. DATE OF BIRTH
MONTH DAY YEAR
6 12 25 | 6. AGE (IN YEARS LAST BIRTHDAY)
61 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
South Baltimore General | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
MD | | | 13b. CITY OR TOWN
Baltimore | 13c. STREET ADDRESS / ZIP CODE
13 Tentmill Ave. 21208 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Louis Williams | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Alice Woppens | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO.
215-14-4694 | 17. INFORMANT ADDRESS
David C. Norris 13 Tentmill Ave. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory Arrest
DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic mucocutaneous Cancer
DUE TO, OR AS A CONSEQUENCE OF (c) 6 months
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 hours |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Sept 1 , 19 86 , to Dec 27 , 19 86 , that (I) (we) last saw the deceased alive on Dec 24 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
K. Miller, M.D. | | DEGREE
Medical Director | | | 22c. DATE SIGNED
12/28/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Kenneth Miller, M.D. | | 22e. ADDRESS
Johns Hopkins Oncology Ctr | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
CREMATION | 23b. DATE
12/29/86 | 23c. NAME OF CEMETERY OR CREMATORY
Westview Crematory | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto., Md. | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Leroy O. Dyatt 4600 Liberty Heights | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 30 1986 | | |
| 25b. REGISTRAR'S SIGNATURE
Julia Gordon-Randall | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the funeral director. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|------------------|---|---|---|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
David B. Northington | | | 2a. DATE KNOWN OF DEATH
12 9 19 86 | | | 2b. HOUR
M | | | |
| 3. SEX
Male | 4. RACE
Black | 5. DATE OF BIRTH
Jan. 27-19 | 6. AGE (IN YEARS)
YRS. MONTHS DAYS HOURS MIN. | 7c. DATE PRONOUNCED DEAD
12 9 19 86 | | 7d. HOUR
10:18 a | | 7e. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Va. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
1805 Rutland Avenue | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Sanitation Dept. | | 12b. KIND OF BUSINESS OR INDUSTRY
City | |
| 13a. STATE
Md. | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
1805 Rutland Ave. 21213 | |
| 14. FATHER'S NAME
Harry Northington | | | | 15. MOTHER'S MAIDEN NAME
Quennie Walker | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
Yes | | | | 16b. SOCIAL SECURITY NO.
W.W. 2 213-09-2098 | | 17. INFORMANT
Mrs. Laura Risher 1720 E. Oliver St. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hypertensive & arteriosclerotic cardiovascular disease
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I a.
Chronic obstructive pulmonary disease | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE
William M. Zane | | | TITLE (SPECIFY)
M.D. Assistant | | | MEDICAL EXAMINER | | DATE SIGNED
12/9/86 | |
| EXAMINER'S NAME
(TYPE OR PRINT)
William M. Zane, M.D. | | | ADDRESS
111 Penn St. Balto.MD. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
12-13-86 | | 23c. NAME OF CEMETERY OR CREMATORY
G.F.U. Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
OWINGS Mills Md. | | |
| 24. FUNERAL DIRECTOR
NAME
Randolph J. Collick | | | ADDRESS
2431 E. Oliver St. | | DEC 16 1986 | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT FORM. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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(VR A15 ME (5))

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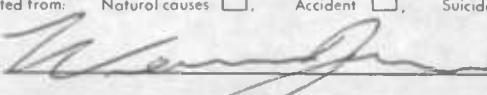

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - VISIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | |
|--|-------------------------|--|---|---|---|---|---|-----------------------------------|
| 1. DECEASED NAME
(TYPE OR PRINT) Melvin R. Nutt | | | 2a. DATE KNOWN OF DEATH
MONTH DAY YEAR
XX 12-20 19 86 | | | 2b. HOUR
M
12:23 a. | | |
| 3. SEX
Male | 4. RACE
Black | 5. DATE OF BIRTH
MONTH DAY YEAR
2-20- 1968 | 6. AGE (IN YEARS)
LAST BIRTHDAY YRS.
18 | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | IF UNDER 24 HRS. | 7c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
12-20 19 86 | | 7d. HOUR
M
12:23 a. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD. | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Arunah Avenue & Longwood Street | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
Maryland | | 13b. COUNTY | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
1931 Harlem Ave. 21217 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Charles Nutt | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Elizabeth Purnell | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
219-92-3903 | | 17. INFORMANT ADDRESS
Elizabeth Purnell 1 Shadwell Ct. 21207 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Multiple Gunshot Wounds (unspecified)
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
approx. 12:20xx 12-20 19 86 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
subject was shot | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
street | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
Arunah Ave. & Longwood St., Balto., Md. | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | |
| ACTUAL SIGNATURE
 | | M.D. Assistant | | MEDICAL EXAMINER | | DATE SIGNED 12-20-86 | | |
| EXAMINER'S NAME
(TYPE OR PRINT) William M. Zane, M.D. | | ADDRESS 111 Penn St., Balto., Md. 21201 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) Burial | | 23b. DATE
12-24-86 | | 23c. NAME OF CEMETERY OR CREMATORY
King Memorial Park | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Maryland | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Bailey Funeral Home 1348 N. Calhoun St. 21217 | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 30 1986 | | | | |
| | | | | | 25b. REGISTRAR'S SIGNATURE
 | | | |

07/84
25M

BP
DHMH - 17
(VR A15 ME (5))

100-100000

STATION 100-100000

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026179 DEC -5 1986

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 -34782

FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | | |
|---|--|--|--|--|--|--|---|---------------------------------|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | | 2b. HOUR | |
| MALCOLM N. OATES | | | | | | December 2, 1986 | | | | 10 P M | |
| 1. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | IF UNDER 1 YEAR | |
| Male | | White | | Nov. 30, 1893 | | | 93 | | | MONTHS DAYS HOURS MIN. | |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | |
| NC | | USA | | | | | Baltimore City MD. | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Baltimore | | Roland Park Place Nursing Center | | | | | Engineer | | | Electrical | |
| 13a. STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS / ZIP CODE | | |
| MD | | | | | Balto. | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 210 Chancery Rd., 21218 | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | |
| James Oates | | | Nora Thompson | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | ADDRESS | | | |
| Yes | | | WW I | | 212 05 6632 | | | Philip Goldsborough, Balto., MD | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> | | | | | | | | | | 2 1/2 hr | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | 4 mo | |
| (b) <u>CVA</u> | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | |
| | | | HOUR A.M. MONTH DAY YEAR | | | | | | | | |
| | | | P.M. 19 | | | | | | | | |
| 21d. INJURY OCCURRED | | | 21e. PLACE OF INJURY | | 21f. LOCATION | | | | | | |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> | | | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | STREET CITY OR TOWN COUNTY STATE | | | | | | |
| AT WORK <input type="checkbox"/> AT PLAY <input type="checkbox"/> | | | | | | | | | | | |
| 22a. I certify that this hospital attended the deceased from <u>12/2</u> 19 <u>86</u> to <u>12/2</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>12/2</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) see the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | DEGREE | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED | | |
| <u>Stuart B. Bell MD</u> | | | | | | | | | 12/3/86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22e. ADDRESS | | | | | | | | |
| Dr. Stuart B. Bell, MD | | | 3501 St. Paul St., Balto., MD | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION | | | |
| Burial | | | 12/5/86 | | Spring Hill | | | Easton, COUNTY MD STATE | | | |
| 24. FUNERAL DIRECTOR NAME | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Henry W. Jenkins & Sons Co. 4905 York Road Balto., MD 21212 | | | | | | DEC 4 1986 | | <u>Julia Gordon-Randall</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with Registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

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Figure 1

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1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 26

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Henry W. Wagner

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

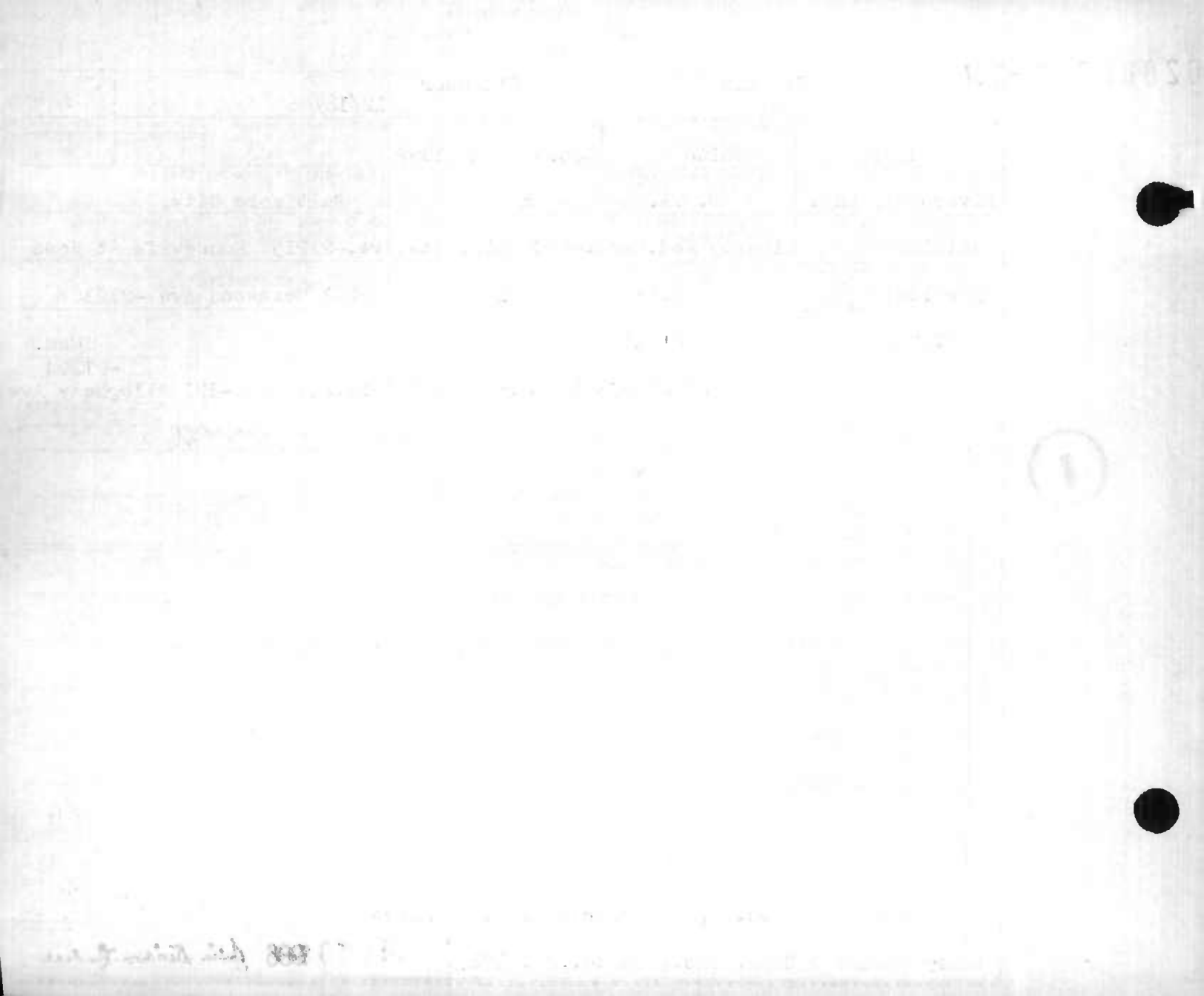
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/cremation permit. Then please refer to the instructions on page 4. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial/cremation. **IMPORTANT:** If item 21 is marked on item 18, shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | REG. NO. | | | | | | | | | |
|---|--|--|--|--|--|---|--|--|--|-----------------------------------|--|-------------------|--|-----------------|--|
| 1. FOR STATE REGISTRAR | | 2a. DECEASED NAME (TYPE OR PRINT) | | 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7a. DATE OF DEATH | | 7b. HOUR | |
| | | FIRST Cecelia MIDDLE O'CONNOR LAST O'CONNOR | | Female | | White | | October 31, 1892 | | 94 YRS | | 12/18/86 | | 11:45 PM | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | |
| Liverpool, Eng. | | U.S.A. | | | | Baltimore City, | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | |
| Baltimore | | Liberty Med. Cent. - 2600 Lib. Hgts. Ave. - 21215 | | Housewife at Home | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. STATE | | 13c. COUNTY | | 13d. CITY OR TOWN | | 13e. INSIDE CITY LIMITS? | | 13f. STREET ADDRESS / ZIP CODE | | | | | |
| Maryland | | | | | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 2203 Homewood Ave. - 21218 | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | |
| FIRST Michael MIDDLE O'Neill LAST O'Neill | | FIRST Unk. MIDDLE Unk. LAST Unk. | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | | | |
| No | | 212-16-2353D | | J. Purdon Wright, Jr., Esq. - 121 Allegheny Ave. - 21204 | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ | | DUE TO, OR AS A CONSEQUENCE OF (b) _____ | | DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| CARDIORESPIRATORY ARREST | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____ | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | | | | | | | | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY | | 21f. LOCATION | | | | | | | | | | | |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> | | AT HOME STREET FACTORY, OFFICE FARM, ETC. | | STREET | | CITY OR TOWN | | COUNTY | | STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED | | | | | | | | | |
| Edwin S. Ch... | | MD | | | | 12/18/86 | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | | | | | | | |
| LEONARD CUNTO | | LIBERTY MEDICAL CENTER | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | | | | | | | |
| Burial | | Dec. 22, 1986 | | Sacred Heart of Jesus | | Dundalk, Balto. County, Md. | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | |
| Henry Sander & Sons, Inc., Balto., Md. 21213 | | DEC 30 1986 | | Julia Davidson-Randall | | | | | | | | | | | |

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Formed. Ex., 2/2/87
STATE REGISTRAR Gbj & item 1STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG NO.

| | | | | | | | | | | | | |
|---|--|---|--|---|--|---|--|--|-----------------------------------|---|-------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
PAUL | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH
KNOWN OR ESTIMATED
<input checked="" type="checkbox"/> 12-11-86
<input type="checkbox"/> 12-11-86 | | 2b. HOUR
M | | |
| 3. SEX
Male | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
2 24 25 | | 6. AGE (IN YEARS)
(LAST BIRTHDAY)
61 YRS. | | 7. IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | | 7c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
12-11-86 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
N.C. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Loch Raven V.A. Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
Md. | | 13b. COUNTY | | 13c. CITY OR TOWN
Balto. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
4108 Woodridge Avenue | | | 21229 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Jewel Odums | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Madora | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WWII | | 17. INFORMANT
Evelyn Odums | | ADDRESS
4108 Woodridge Avenue | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Laryngeal spasm (adverse reaction)
DUE TO, OR AS A CONSEQUENCE OF
(b) Biopsy
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
Primary | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
? P.M. 12 ? 1986 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
following laryngeal biopsy | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
hospital | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
Loch Raven VA. Hospital, Baltimore, Md. | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | |
| ACTUAL SIGNATURE
<i>Margarita A. Korell</i> | | TITLE (SPECIFY)
Assistant MEDICAL EXAMINER | | | | | | | | DATE SIGNED
12-12-86 | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Margarita A. Korell, M.D. | | ADDRESS
111 Penn Street | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
12/16/86 | | 23c. NAME OF CEMETERY OR CREMATORY
Garrison Forest Vet. Cem | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Owings Mills, Md. | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Wm C March F/H West 4300 Wabash Ave. | | 25a. DATE REC'D. BY REGISTRAR
DEC 16 1986 | | 25b. REGISTRAR'S SIGNATURE
<i>John Gordon-Randall</i> | | | | | | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

053-2-11-2



026393 DEC 10 1986

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

BEATRICE

ODINMA

2a. DATE KNOWN OF DEATH ☒ MONTH DAY YEAR 12 3 1986 2b. HOUR M

3. SEX

F

4. RACE

Blk.

5. DATE OF BIRTH

10/21/86

6. AGE (IN YEARS LAST BIRTHDAY)

1 YRS. 14

IF UNDER 1 YR.

MONTHS DAYS

IF UNDER 24 HRS.

HOURS MIN.

2c. DATE PRONOUNCED DEAD 12 3 1986 2d. HOUR M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Balt. Md.

7b. CITIZEN OF WHAT COUNTRY?

U. S. A

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore City MD.

10. CITY OR TOWN OF DEATH

Baltimore

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION

2810 Reisterstown Rd.

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

None

12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF IN HOURS HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE MD. 13b. COUNTY Balt.

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS

2810 Reisterstown Rd

14. FATHER'S NAME

Nathaniel

MIDDLE

LAST

Odinma

15. MOTHER'S MAIDEN NAME

Vr. S

MIDDLE

LAST

Odinma

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)

16b. SOCIAL SECURITY NO.

17. INFORMANT

Vr. S

ADDRESS

2810 Reisterstown Rd

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Sudden Infant Death Syndrome

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS

UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐ AT WORK ☐ AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that I took charge of the remains described above, held on

Autopsy ☒Inspection ☐Inquiry ☐

and in my opinion

death resulted from: Natural causes ☒Accident ☐Suicide ☐Homicide ☐Undetermined manner ☐

ACTUAL SIGNATURE

TITLE (SPECIFY)

M.D. Assistant

MEDICAL EXAMINER

DATE SIGNED

12-4-86

EXAMINER'S NAME

Charles P. Kokes, M.D.

ADDRESS 111 Penn St., Balto., MD 21201

23a. BURIAL, CREMATION, REMOVAL

23b. DATE

12/8/86

23c. NAME OF CEMETERY OR CREMATORY

Mt. Auburn Cem.

23d. LOCATION

Balt.

COUNTY

STATE

Md.

24. FUNERAL DIRECTOR

ADDRESS

25a. DATE REC'D. BY REGISTRAR

DEC 5 1986

25b. REGISTRAR'S SIGNATURE

Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN THE SPACE PROVIDED ON PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-1, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

056310 10-000



028988 JAN - 5107

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|---|--|---|---|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
BOYD M. OGELSBY, JR. | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 30 86 | | | 2b. HOUR
8:07 A M | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Nov. 14, 1909 | | 6. AGE (IN YEARS LAST BIRTHDAY)
77 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
PA | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Mercy Hospital | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Steel Worker | | 12b. KIND OF BUSINESS OR INDUSTRY
Bethlehem | | |
| 13a. STATE
MD | | | 13b. COUNTY | | 13c. CITY OR TOWN
Balto. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Boyd M. Ogelsby | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Elmira Steuart | | | 13e. STREET ADDRESS / ZIP CODE
1 W. Conway St., 21201 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
215 05 3661 | | 17. INFORMANT
ADDRESS
Dianne G. Thompson, Balto., MD | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Respiratory Failure</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic Obstructive Pulmonary Disease</u>
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/20</u> 19 <u>86</u> , to <u>12/30</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>12/30</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>Michael A. Syba</u> | | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF <input checked="" type="checkbox"/>
DIRECTOR OF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<u>12/30/86</u> | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MICHAEL A. SYBA MD | | | 22e. ADDRESS
MERCY HOSPITAL 301 ST. PAUL PL. BALTIMORE MD | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
1/2/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Druid Ridge | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Pikesville, MD MD | | | |
| 24. FUNERAL DIRECTOR
NAME Henry W. Jenkins & Sons Co.
ADDRESS 4905 York Road Balto., MD 21212 | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 31 1986 | | 25b. REGISTRAR'S SIGNATURE
<u>Julia Davidson-Randall</u> | | |

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital as attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please enclose both papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other significant event, the medical examiner must be notified and a medical certificate must be filed with this one.

028274 DEC 15 1986

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | | | | | | | | |
|---|--|---------|--|--|--|-------------------|--|---|--|---|--|---|--|-------|--|--|--|------|--|----------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH | | <input checked="" type="checkbox"/> MONTH | | DAY | | YEAR | | 2b. HOUR | | | | | |
| THOMAS | | Stephen | | O'KEEFE | | Sr. | | 12 | | 17 | | 19 | | 86 | | M | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | MONTH | | DAY | | YEAR | | 2d. HOUR | |
| male | | white | | Dec. 26, 1915 | | 70 YRS. | | | | | | 12 | | 17 | | 19 | | 86 | | 3:45 P M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | |
| New Jersey | | | | USA | | | | | | | | Baltimore City MD. | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | |
| Baltimore | | | | University Hospital (STU) | | | | | | | | trucking | | | | | | | | | |
| 13a. STATE | | | | 13b. CITY OR TOWN | | | | 13d. INSIDE CITY LIMITS? | | | | 13e. STREET ADDRESS | | | | | | | | | |
| Maryland | | | | Washington | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 955 Greenbriar Road 21740 | | | | | | | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT ADDRESS | | | | | |
| Eugene J. O'Keefe | | | | Rose E. McCape | | | | yes | | | | W.W.II | | | | 053-16-9328 | | | | | |
| | | | | | | | | | | | | Jane O'Keefe, Hagerstown, Md. | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Multiple injuries with complications
8147
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? | | | | | | | | | |
| | | | | | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR XX MONTH DAY YEAR
7:10 P.M. 12-6- 19 86 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
Pedestrian struck by auto. | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
road | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
Rt. 11 & Club Rd., Hagerstown, Washington, MD | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
<i>Charles P. Kokes</i> | | | | TITLE (SPECIFY)
M.D. Assistant | | | | MEDICAL EXAMINER | | | | DATE SIGNED 12-18-86 | | | | | | | | | |
| EXAMINER'S NAME
(TYPE OR PRINT) | | | | Charles P. Kokes, M.D. | | | | ADDRESS 111 Penn St., Balto., MD | | | | 21201 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | | | | | | | |
| burial | | | | Dec. 20, 1986 | | | | Rest Haven Cemetery | | | | Hagerstown, Wash., Maryland | | | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME | | | | ADDRESS | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | |
| MINNICH FUNERAL HOME | | | | 415 E. Wilson Blvd., Hagerstown, Md. 21740 | | | | DEC 24 1986 | | | | <i>Julia Davidson-Rodden</i> | | | | | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP
DHMH - 17
(VR AIS ME (S))

08030

25X COM LINE

31

029530 JAN - 97

FOR
1. STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|---|--|---|---|---|--|--|---|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) ROOSEVELT NMI ONEAL | | | 2a. DATE OF DEATH
MONTH 12 DAY 25 YEAR 86 | | | 2b. HOUR
8 A M | | | | | |
| 3. SEX
MALE M | | 4. RACE
BLACK B | | 5. DATE OF BIRTH
MONTH 6 DAY 12 YEAR 28 | | 6. AGE (IN YEARS LAST BIRTHDAY)
58 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
USA N. Carolina | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTO. CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
BALTO | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNIV of MD Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Chemical | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
MD | | | 13b. COUNTY | | 13c. CITY OR TOWN
BALTO. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
1010 W. BALTO ST 21223 | | |
| 14. FATHER'S NAME
FIRST BEN MIDDLE LAST ONEAL | | | 15. MOTHER'S MAIDEN NAME
FIRST HATTIE MIDDLE LAST COLE | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NONK | | | 16b. SOCIAL SECURITY NO.
240 36 8855 | | 17. INFORMANT
ADDRESS
Charlene Boyd - daughter | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiopulmonary arrest / EMD
DUE TO, OR AS A CONSEQUENCE OF (b) Severe Biventricular Failure
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
20 min
months | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Severe chronic obstructive pulmonary disease | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) this hospital attended the deceased from 12/17 19 86 , to 12/25 19 86 , that (I) <input checked="" type="checkbox"/> saw the deceased alive on 12/25 19 86 , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Glenn D Gilmer MD | | | DEGREE | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED
12/25/86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Glenn D Gilmer MD | | | 22e. ADDRESS
Univ of MD Hospital 22 S. Greene St | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
BURIAL | | | 23b. DATE
12/31/86 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Auburn Cemetery | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Westport B.C. Md. | | | |
| 24. FUNERAL DIRECTOR
NAME
CHARLES A. RICE | | | FSPA 1300 EUTAW PLACE | | | 25a. DATE REC'D. BY REGISTRAR
JAN 7 1987 | | | 25b. REGISTRAR'S SIGNATURE
Julia Tidwell-Randall | | |

MEDICAL CERTIFICATION

29

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please forward this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Handwritten notes at the top of the page, including a date "25-11-19" and some illegible text.

Handwritten notes in the middle section, starting with "25-11-19" and "25-11-19".

Handwritten notes in the lower middle section, including a circled "1" on the right margin.

Handwritten notes at the bottom of the page, including a date "25-11-19" and some illegible text.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 86 34189

1. FOR
STATE
REGISTRAR

| | | | | | |
|--|---|---|---|---|--|
| DECEASED NAME
FIRST MIDDLE LAST
ISRAEL OLIVER | | 2a. DATE OF DEATH
MONTH DAY YEAR
DEC 6 86 | | 2b. HOUR
M | |
| 3. SEX
MALE | 4. RACE
BLACK | 5. DATE OF BIRTH
MONTH DAY YEAR
5 08 19 | | 6. AGE (IN YEARS LAST BIRTHDAY)
67 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTO. City MD. | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Bon Secours Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
retired | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
md | | 13b. COUNTY | 13c. CITY OR TOWN
BALTO | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
437 North Stricker ST 21217 |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Chas (ZERG) OLIVER | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Blanche Gam Brell | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
214-444631 | 17. INFORMANT
ADDRESS
Pearl Oliver 937 N. Stricker ST | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1: DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>cardiac arrest</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASHD</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost }
DUE TO, OR AS A CONSEQUENCE OF (c) <u>hypertension</u> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>UREMIA + multi organ failure</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5 Dec 86</u> to <u>Dec 86</u> , that (I) (we) lost the deceased above on <u>5 Dec 86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>Curtis E Davis</u> | | | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
CURTIS E DAVIS | | | | 22e. ADDRESS
Bon Secours Hosp 21223 | |
| 23a. BURIAL, CREMATION, REMOVAL
(TYPE OR PRINT)
Burial | | 23b. DATE
12/10/86 | 23c. NAME OF CEMETERY OR CREMATORY
St Rest Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY
Harmony MD |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
March Funeral Home West 4300 Wabash Avenue | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 10 1986 | |
| | | | | 25b. REGISTRAR'S SIGNATURE | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page a may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page b should be detached for use on the burial transit permit. Then please remove carbon papers. Page 1 and 2 will be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

027580

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|-------------------|--|-----------------|-----|------------|----------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH | | MONTH | DAY | YEAR | 2b. HOUR | |
| Ruth | | | | | | Oppenheimer | | 12 | | 16 | 86 | 2:00 p.m. | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | | | |
| Female | | White | | 4 15 20 | | 66 | | MONTHS | | DAYS | | HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | |
| Germany | | U.S. | | | | Baltimore | | | | | | MD. | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | |
| Baltimore City | | The Union Memorial Hospital | | Psychologist | | Hospital | | | | | | | | |
| 13a. USUAL RESIDENCE (IF NOT IN HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. CITY OR TOWN | | 13c. INSIDE CITY LIMITS? | | 13d. STREET ADDRESS / ZIP CODE | | | | | | | | |
| Md. | | Balto. | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 15 Stoneridge Court | | | | | | 21239 | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | |
| Ludwig | | Else | | No | | 298-38-4604 | | Greenvale | | New York | | | | |
| | | Oppenheimer | | | | | | Dr. Hans Grunwald | | 8 Marylane | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | IMMEDIATE CAUSE (a) | | cardiopulmonary arrest | | immediate | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | (b) | | Bacterial meningitis | | 7 days | | | | | | | | |
| | | (c) | | Urosepsis | | 7 day | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | |
| N/A | | N/A | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED | | | | | | | | | | |
| | | N/A | | N/A | | | | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY | | 21f. LOCATION | | | | | | | | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | STREET | | CITY OR TOWN | | COUNTY | | STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from | | December 9, 1986 | | to | | December 16, 1986 | | | | | | | | |
| saw the deceased alive on | | December 16, 1986 | | and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. | | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | | | | | | | | | | |
| Stacy O. Ross, MD | | | | 12/16/86 | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | | | | | | |
| Stacy O. Ross, MD | | Union Memorial Hospital Balt. Md 21218 | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | | | | | | |
| Removal | | 12-17-86 | | | | CITY OR TOWN | | COUNTY | | STATE | | | | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REGD. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | |
| NAME | | ADDRESS | | | | | | | | | | | | |
| Anatomy Board | | Balto., Md. | | | | | | | | | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be retained by the hospital or attending physician. The low requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and duly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

0511

(M)

REC 18 1958

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1 DECEASED NAME
(TYPE OR PRINT)
David C. Orem, Sr. | | | | 2a DATE OF DEATH
MONTH DAY YEAR
December 15 TH 1986
2b HOUR
8:06 P.M. | | | |
| 3 SEX
Male | | 4 RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
06 17 19 | | 6 AGE (IN YEARS LAST BIRTHDAY)
67
YRS. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | |
| 10 CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Union Memorial Hospital 21218 | | | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | |
| 13a STATE
Maryland | | | | 13b COUNTY
-- | | 13c CITY OR TOWN
Baltimore | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
Graydon Orem | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Florence (unknown) | | 13d INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WW II | | 17. INFORMANT ADDRESS
Gary Frederick 4405 Hickory Avenue 21211 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ACUTE G.I. BLEED - LOWER
DUE TO, OR AS A CONSEQUENCE OF
(b) METASTATIC COLON CARCINOMA
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a DATE OF OPERATION
DECEMBER 15, 1986 | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED
ACUTE BLEED | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NO: WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22 I certify that (I) (this hospital) attended the deceased from DEC 15, 19 86, to DEC 15, 19 86, that (I) (we) last saw the deceased alive on DEC 15, 19 86, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. | | | | | | | |
| 22b SIGNATURE
Paul S. Cooper | | DEGREE
M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c DATE SIGNED
12/15/86 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)
Paul S. Cooper | | 22e ADDRESS
Union Memorial Hospital | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b DATE
12/19/86 | | 23c NAME OF CEMETERY OR CREMATORY
St. Mary's Cemetery | | 23d LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Maryland | |
| 24 FUNERAL DIRECTOR
NAME
A. Alan Seitz, Jr. | | | | ADDRESS
36H-15-19 Chestnut Ave. 21211 | | 25a DATE REC'D. BY REGISTRAR
DEC 17 1986 | |
| | | | | | | 25b REGISTRAR'S SIGNATURE
Deborah R. Rando | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|---|--|---|--|---|---|---|---------------------------|--|--|----------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Carole W. Osborne | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 / 9 / 86 | | 2b. HOUR
345 AM | | | | |
| 3. SEX
Male | | 4. RACE
white | | 5. DATE OF BIRTH
MONTH DAY YEAR
5 21 1908 | | 6. AGE (IN YEARS LAST BIRTHDAY)
78 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Good Samaritan Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Surveyor | | 12b. KIND OF BUSINESS OR INDUSTRY
Penn RR | | | |
| 13a. STATE
MD | | 13b. COUNTY
XXXXXX | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
2401 Beechland Ave. 21214 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Carlton Osborne | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Rose Ellen Whitekettle | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
714-18-3650 | | 17. INFORMANT ADDRESS
Ellen E. Osborne, 2401 Beechland Ave. 21214 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Sepsis secondary to ischemic bowel
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 days | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a
congestive heart failure, COPD, myocardial infarction, pneumonia. | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11 / 25 / 19 86 to 12 / 9 / 19 86 , that (I) (we) lost
saw the deceased alive on 12 / 9 / 86 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Ghinwa Duhwati | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
GHINWA DUHWATI | | | | 22e. ADDRESS
Good Samaritan Hospital | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Dec. 12, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY
Parkwood | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Md. | | | | | |
| 23e. FUNERAL HOME FOR NAME ADDRESS
ROBERT C. ALTENBURG FUNERAL HOME, INC.
6009 Harford Rd., Balto., Md. 21214 | | | | | | 23f. DATE REC'D. BY REGISTRAR
DEC 11 1986 | | 23g. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | | |

BP

05777 77750



026739 DEC

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 3 4 7 9 3

REG. NO.

| | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|--------------------------|--|--------------------------------|--|--------|--|------|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH | | MONTH | | DAY | | YEAR | | 2b. HOUR | |
| THOMAS J. OSBY | | | | | | | | 12/4/86 | | | | | | | | M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 14 HRS. | | MONTHS | | DAYS | | HOURS | |
| M | | B | | June 6, 1906 | | 80 | | YRS. | | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | MD. | |
| Fitzgerald, Ga. | | U.S.A. | | | | Balto. | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | |
| Balto. | | (res.) 2501 Violet Ave. | | n/a | | n/a | | | | | | | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS / ZIP CODE | | | | | | | |
| MD. | | BALTO. | | Balto. | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 2501 Violet Ave. | | 21215 | | | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | |
| THOMAS OSBY | | Pearl Osby | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | | | | | |
| no | | 219-01-3244A | | Zelma Ben | | 2501 Violet Ave. | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>cardiac arrest</u> | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | (b) <u>myocardial infarction</u> | | DUE TO, OR AS A CONSEQUENCE OF | | (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | | | | | | | | | | | | | |
| WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | STREET | | CITY OR TOWN | | COUNTY | | STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12-16</u> 19 <u>86</u> , to <u>12</u> 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>12-16</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (we did not) view the body after death. | | 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | | | | | | | | | | | |
| | | <u>EC V ORGOLINI</u> | | MD | | 12-8-86 | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | | | | | | | | | |
| EC V ORGOLINI | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | | | | | | | | | |
| Burial | | 12/9/86 | | Mt. Zion | | Baltimore, Maryland | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | |
| NAME | | ADDRESS | | | | | | | | | | | | | | | |
| Leroy O. Dyett | | 4600 Liberty Heights | | | | | | | | | | | | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon 1 and 2 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DEC 10 1986

Julia Dyett

05832 (C112)



2025-001-127

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

4. DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Howard Francis OSTERMANN

2a. DATE OF DEATH

MONTH DAY YEAR

2b. HOUR

December 26, 1986

6:45P M

3. SEX

Male

4. RACE

White

5. DATE OF BIRTH

Feb. 28, 1926

6. AGE (IN YEARS LAST BIRTHDAY)

60

IF UNDER 1 YEAR

IF UNDER 24 HRS

YRS.

MONTHS

DAYS

HOURS

MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Maryland

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore City,

MD.

10. CITY OR TOWN OF DEATH

Baltimore

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

Ashburton Nursing Home

12a. USUAL OCCUPATION

Machinist

12b. KIND OF BUSINESS OR INDUSTRY

Brewery

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Maryland

13b. COUNTY

13c. CITY OR TOWN

Baltimore

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS

3654 Dudley Avenue 21213

14. FATHER'S NAME

Frank G. Ostermann

15. MOTHER'S MAIDEN NAME

Emma Eslinger

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

No

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.

220-12-6526

17. INFORMANT

Veronica Ostermann 3654 Dudley Avenue 21213

ADDRESS Baltimore, MD.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

BRAIN TUMOR

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

(b)

CUA

DUE TO, OR AS A CONSEQUENCE OF

(c)

ASCVD

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

1958

1978

3 years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

SEIZURE DISORDER

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐OR CONTRIBUTING ☐ CAUSE OF DEATH

(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐AT WORK ☐ AT WORK ☐

21e. PLACE OF INJURY

(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from 19 87 to 12/26 19 86, that (I) (we) lost
saw the deceased alive on Dec 26 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

22c. DATE SIGNED

ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

12/27/86

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

Allan H. Macht, M.D.

22e. ADDRESS

Baltimore, MD.
101 W. Read Street (Medical Arts Bldg)

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Cremation

23b. DATE

12/27/86

23c. NAME OF CEMETERY OR CREMATORY

Security Process Inc

23d. LOCATION

CITY OR TOWN

COUNTY

STATE

Baltimore Co., MD.

24. FUNERAL DIRECTOR

NAME

Dippel Funeral Homes, Inc.

ADDRESS

7110 Belair Road Baltimore, Maryland 21206

25a. DATE REC'D. BY REGISTRAR

DEC 29 1986

25b. REGISTRAR'S SIGNATURE

Julia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then return this certificate to the State Dept. of Health and Mental Hygiene prior to burial or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or at any other time, the medical examiner must be notified of the event.

RECEIVED
FEB 10 1964

2000 DEC 19



FOR COTTON

029050 JAN - 5 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
ELWOOD OTT, SR. | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 31 86 | | | 2b. HOUR
12 05 AM | |
| 3. SEX
male | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
04 30 14 | | 6. AGE (IN YEARS LAST BIRTHDAY)
72 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
St Agnes Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Truck Driver | |
| 12b. KIND OF BUSINESS OR INDUSTRY
Acme Mkts | | | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE Maryland 13b. COUNTY Howard 13c. CITY OR TOWN Elkridge | | | | | | | |
| 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
36 Reile Drive 21227 | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Charles Ott | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Rose Emrine | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
212-07-0018 | | 17. INFORMANT
Donald Vincent, Sr. 1836 Colmar Rd. 21207 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebro-vascular insufficiency
DUE TO, OR AS A CONSEQUENCE OF
(b) Cerebral ischemia
DUE TO, OR AS A CONSEQUENCE OF
(c) Mass, Left Upper Lung, CHF
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
IDDM | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Gonzalo F. Urbano | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
12/31/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Gonzalo F. Urbano | | 22e. ADDRESS
St. Agnes Hospital | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
1/3/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Woodlawn Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Woodlawn Baltimore Md | |
| 24. FUNERAL DIRECTOR
NAME
Hubbard Funeral Home, Inc. | | ADDRESS
4107 Wilkens Ave. | | 25a. DATE REC'D. BY REGISTRAR
DEC 31 1986 | | 25b. REGISTRAR'S SIGNATURE
Julia... | |

MEDICAL CERTIFICATION

9-19

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

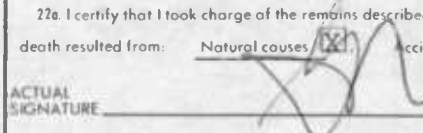



[Faint, mostly illegible text covering the majority of the page. The text appears to be a technical report or document, possibly describing the components shown in the diagrams.]

**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO.

FOR
STATE
REGISTRAR

| | | | | | | | | |
|--|-------------------------|--|--|---|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Donald R. Otto | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH 12/ DAY 21/ YEAR 86 | | | 2b. HOUR M | | |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH Apr. DAY 18 YEAR 35 | 6. AGE (IN YEARS)
(LAST BIRTHDAY) 51 YRS. | IF UNDER 1 YR.
MONTHS 1 DAYS 1 HOURS 1 MIN. | 7c. DATE PRONOUNCED DEAD
12/ 21/ 19 86 | 7d. HOUR P M | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD. | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
1247 W. Lombard St. | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Head of Security | | 12b. KIND OF BUSINESS OR INDUSTRY
Roper Eastern | |
| 13a. STATE
Maryland | | | 13b. CITY OR TOWN
Baltimore | | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS
1247 W. Lombard Street, 21223 | |
| 14. FATHER'S NAME
FIRST Harry MIDDLE Otto LAST Agnes | | | 15. MOTHER'S MAIDEN NAME
FIRST M. MIDDLE Dunkerly LAST Dunkerly | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) Yes (IF YES, GIVE WAR OR DATES) Korea | | |
| 16b. SOCIAL SECURITY NO.
217-30-3938 | | | 17. INFORMANT
Josephine O. Coburn, 2633 Hafer Street | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Alcoholism, Fatty Cirrhosis
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | |
| ACTUAL SIGNATURE
 | | | TITLE (SPECIFY)
M.D. Assistant | | | DATE SIGNED 12/22/86 | | |
| EXAMINER'S NAME (TYPE OR PRINT)
Gregory R. Kauffman, M.D. | | | ADDRESS 111 Penn St. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
12/27/86 | | 23c. NAME OF CEMETERY OR CREMATORY
Garrison Forest Cemetery | | 23d. LOCATION
CITY OR TOWN Owings Mills COUNTY Baltimore STATE Md. | | |
| 24. FUNERAL DIRECTOR
NAME Hubbard Funeral Home, Inc., ADDRESS 4107 Wilkens Ave. | | | 25a. DATE REC'D. BY REGISTRAR
21229 | | 25b. REGISTRAR'S SIGNATURE
 | | | |

MEDICAL CERTIFICATION

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN THE SPACE PROVIDED. THIS CERTIFICATE IS VALID FOR 10 DAYS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSFER PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25M

BP
DHMH - 17
(VR A15 ME (5))

DEC 24 1986



027597 DEC 9 1986

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 3 4 1 9 1

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
THELMA OTTO | | | 2a. DATE OF DEATH
MONTH DAY YEAR
December 16, 1986 | | | 2b. HOUR
9:10 PM | |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
November 20, 1917 | | 6. AGE (IN YEARS LAST BIRTHDAY)
69 YRS | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
St. Agnes Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Buyer | | 12b. KIND OF BUSINESS OR INDUSTRY
Stewart & Co. | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE Maryland 13b. COUNTY Baltimore 13c. CITY OR TOWN Catonsville | | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
102 Oakdale Avenue 21228 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Frederick L. Ripley | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Anna Becker | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
212-28-5533 | | 17. INFORMANT
ADDRESS
Lewis Otto Same as # 13 | | | |

| | | |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Ventricular fibrillation</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Massive myocardial infarction</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
|--|--|---|

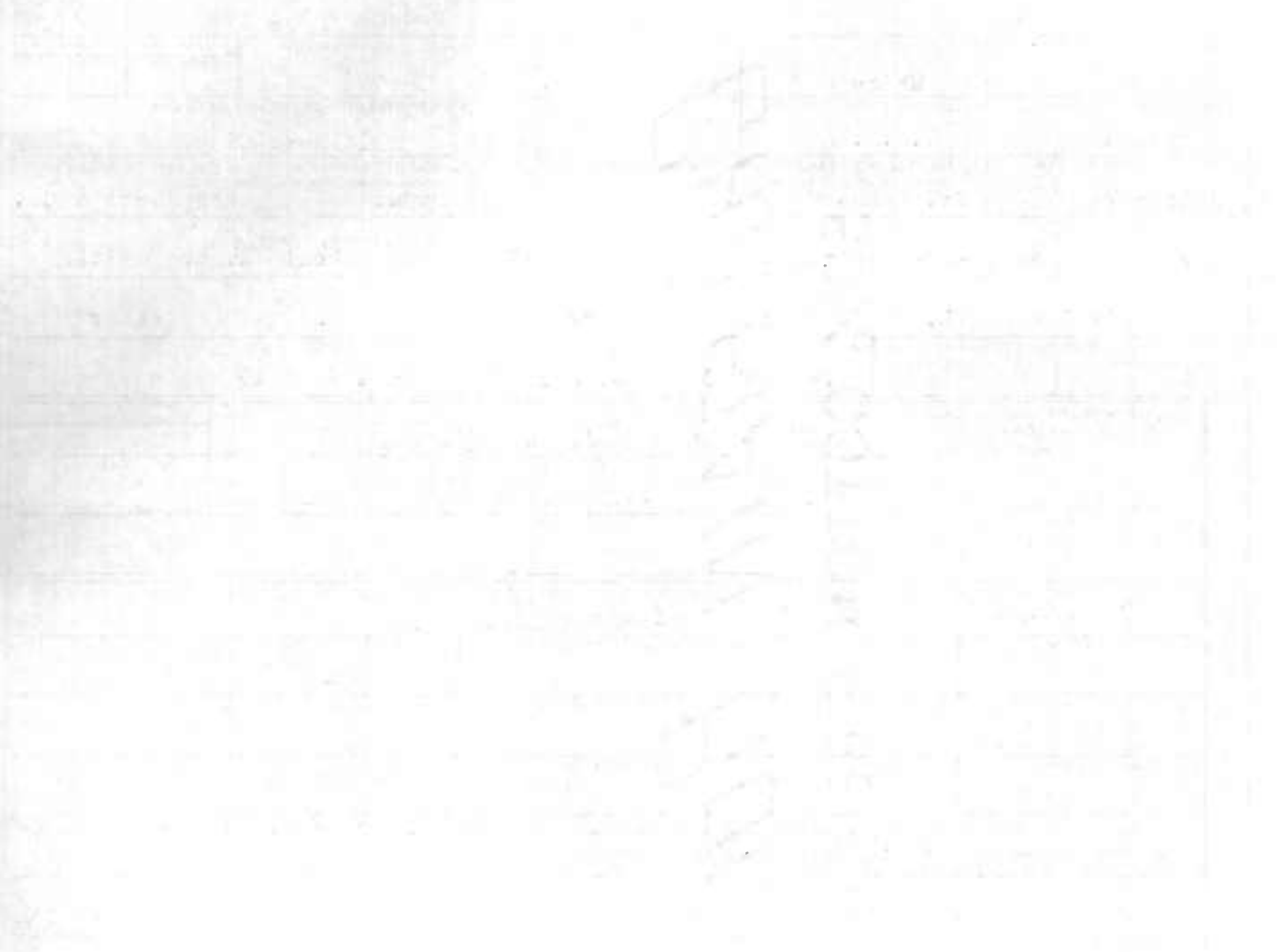
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Diabetes mellitus, hypertension

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>27 Jan</u> , 19 <u>78</u> , to <u>16 Dec</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>15 Dec</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>James E. Rowe</u> M.D. | | | | DEGREE
M.D. | | 22c. DATE SIGNED
12/17/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
James E. Rowe M.D. | | | | 22e. ADDRESS
413 Commonwealth Avenue, Baltimore, MD. | | | |

| | | | |
|--|-----------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
12/19/86 | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park Cemetery | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Maryland |
|--|-----------------------|--|--|

| | | | |
|--|--|--|--|
| 24. FUNERAL DIRECTOR
Leroy L. & Russell C. Witzke Funeral Homes P.A.
1630 Edmondson Avenue, Catonsville, MD. 21228 | | 25a. DATE REC'D. BY REGISTRAR
DEC 18 1986 | 25b. REGISTRAR'S SIGNATURE
<u>John Anderson</u> |
|--|--|--|--|

057001-113



28096 DEC 31

FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|---|--|---|---|---|---|--|--|
| 1. DECEASED NAME
(Type or Print)
FIRST MIDDLE LAST
ARTHUR C. PACHECO | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 25 '86 | | | 2b. HOUR
2:15 M | | | |
| 3. SEX
Male | | 4. RACE
Cauc. | | 5. DATE OF BIRTH
MONTH DAY YEAR
11 18 '21 | | 6. AGE (IN YEARS LAST BIRTHDAY)
65 YRS. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Mass. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
F.S. Key | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | | 12b. KIND OF BUSINESS OR INDUSTRY
B.S. Co. | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John Pacheco | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Maria Manado | | 13e. STREET ADDRESS
83 Kinship Road, Balto., Md. 21222 | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WW II
016-16-5418 | | 17. INFORMANT
ADDRESS
Carolyn F. Pacheco - 83 Kinship Rd. 21222 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiac Dysrhythmia</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Myocardial Infarction</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>ASCD</u> | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
<u>Respiratory Inefficiency 2° to Pleuritis and Emphysema.</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
<u>Hemoptysis</u> | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 <u>78</u> to <u>12/23</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>12/23</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | |
| 23. SIGNATURE
<u>Victor R. Hrehorovich</u> | | | | DEGREE
M.D. | | 22c. DATE SIGNED
12/25/86 | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF <input type="checkbox"/>
DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> | |
| 24. PHYSICIAN'S NAME (TYPE OR PRINT)
VICTOR R. HREHOROVICH | | | | 22e. ADDRESS
3001 S. Howard Street
Baltimore, Md. 21230 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
12/29/86 | | 23c. NAME OF CEMETERY OR CREMATORY
Oak Lawn | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, MD. | | 25. DATE REC'D. BY REGISTRAR
DEC 29 1986 | |
| 24. FUNERAL DIRECTOR
NAME
Walter Dabrowski - 1005 Dundalk Avenue 21224 | | | | 25. REGISTRAR'S SIGNATURE
<u>Julia Deaton-Radner</u> | | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT) If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director. Page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified as soon as possible.

Item # 2a, 1/12/87 ra

1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|---|---|---|--|--|
| DECEASED NAME
(TYPE OR PRINT) MICHAEL B. PAJTIS | | | 2b. DATE OF DEATH
MONTH 12 DAY 22 YEAR 1986 | | 2b. HOUR
3:13 P M |
| 3 SEX
MALE | 4. RACE
CAUCASIAN | 5. DATE OF BIRTH
MONTH March DAY 26 YEAR 1902 | | 6. AGE (IN YEARS LAST BIRTHDAY)
84 YRS. | IF UNDER 1 YEAR
MONTHS 0 DAYS 0 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Church Hospital Corporation | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Bridgeman | | 12b. KIND OF BUSINESS OR INDUSTRY
B & O Railroad |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE Maryland 13b. COUNTY --- 13c. CITY OR TOWN Baltimore | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST Joseph MIDDLE --- LAST Pajtis | | | 15. MOTHER'S MAIDEN NAME
FIRST Agnes MIDDLE --- LAST Krzyzowski | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO.
705-09-6543 | | 17. INFORMANT
Michael F. Pajtis - 2119 Bank St. #21231 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDROPULMARY ARREST | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| DUE TO, OR AS A CONSEQUENCE OF (b) CHRONIC LUNG DISEASE AND | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) ATHEROSCLEROTIC HEART DISEASE | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: --- | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
--- P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
AT WORK <input type="checkbox"/> NO! WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from DECEMBER 22, 1986 to DECEMBER 22, 1986 , that (I) (we) last saw the deceased alive on DECEMBER 22, 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<i>Alan Rosenbloom MD</i> | | DEGREE
MD. | | 22c. DATE SIGNED
Dec. 22, 1986 | |
| 22b. THE PHYSICIAN'S NAME (TYPE OR PRINT)
ALAN ROSENBLOOM MD. | | 22e. ADDRESS
100 N. Broadway - Baltimore, Maryland 21231 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | 23b. DATE
12/26/86 | 23c. NAME OF CEMETERY OR CREMATORY
St. Stanislaus Cem. | 23d. LOCATION
CITY OR TOWN Baltimore City, COUNTY Md. STATE | | |
| 24. FUNERAL DIRECTOR
NAME George A. Weber & Sons Inc.-705 S. Ann Street ADDRESS | | | 25a. DATE REC'D. BY REGISTRAR DEC 23 1986 25b. REGISTRAR'S SIGNATURE <i>Julia D...</i> | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use on the burial-transit permit. Then please return the completed pages 3 and 4 to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition. IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|---|---------------|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
6 DEC 22 86 DANIEL WESTLEY PALMER | | | 2a. DATE OF DEATH
MONTH DAY YEAR
December 16, 1986 | | 2b. HOUR
M | | |
| 3. SEX
Male | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
3 12 1900 | | 6. AGE (IN YEARS LAST BIRTHDAY)
86 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY, MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
1727 W. Lanvale Street 3rd Floor | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
DAVIDSON CHEMICAL | |
| 12b. KIND OF BUSINESS OR INDUSTRY
RETIRED | | 13a. STREET ADDRESS / ZIP CODE
1727 W. LANVALE ST. 3rd fl. 21217 | | 13b. CITY OR TOWN
BALTO. | | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
JAMES PALMER | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ARELLIA | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
/ ? | |
| 17. INFORMANT
ADDRESS
ALLEYNA M. PALMER JONES 2255 SIDNEY AV | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardio pulmonary arrest (at home)</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Anaemia, & U. T. I, Decubitus ulcer.</u>
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11-8-86</u> , 19 <u>86</u> , to <u>12-15</u> , 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>12-15</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>G. Shah</u> | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>DR. G. SHAH M.D.</u> | | 22e. ADDRESS
<u>2105, N. CHARLES ST 21218.</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
12-19-86 | | 23c. NAME OF CEMETERY OR CREMATORY
MOUNT AUBURN CEM. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTO., MD | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
March Funeral Homes 1101 East North Avenue | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 18 1986 | | 25b. REGISTRAR'S SIGNATURE
<u>Julia Benson-Randall</u> | |

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JAN-20

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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REG. NO.

| | | | | | | | | | | | |
|---|--|--|--|---|---|--|---|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
JAMES N PANTAZES | | | 2a. DATE OF DEATH MONTH DAY YEAR
12/21/86 | | 2b. HOUR
5 PM | | | | | | |
| 3. SEX
Male | | 4. RACE
WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR
10 26 1919 | | 6. AGE (IN YEARS LAST BIRTHDAY)
67 YRS. | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
GREECE | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
City (Baltimore) MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNIVERSITY of Md. Hospital | | | | 12a. USUAL OCCUPATION (Last occupation if deceased (LIFE)
Restaurateur. | | 12b. KIND OF BUSINESS OR INDUSTRY
Own Business | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE
Md. | | | | | 13b. COUNTY
HOWARD | | 13c. CITY OR TOWN
SAVAGE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Nicholas James Pantazes | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
UNAV. | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
Yes | | | | | 16b. SOCIAL SECURITY NO.
108-14-0074 | | 17. INFORMANT ADDRESS
NORTH ARUNDEL HOSP | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral Hemorrhage</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Stroke</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/21</u> 19 <u>86</u> , to <u>12/21</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>12/21</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
R. BURGEMAN | | | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
12/21/86 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
R BURGEMAN | | | | | | 22e. ADDRESS
22 S GREENE ST BALTO | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | 23b. DATE
12/24/86 | | 23c. NAME OF CEMETERY OR CREMATORY
St. Demetrius Greek Orthodox Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Annapolis(A.A.) Md. | | | |
| 24. FUNERAL DIRECTOR
Richard A. Coleman Upper Marlboro, Md. 20772 | | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 30 1986 | | 25b. REGISTRAR'S SIGNATURE
Dorinda R. Rader | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please move our barbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | REG. NO. | |
|--|--|--|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) MALCOLM PARRISH | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12-27-86 | |
| 3. SEX
MALE | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH
MONTH DAY YEAR
Nov. 9 1903 | | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
83 | | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Mass. | | 8. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Mass. | | 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Francis Scott Key Med. Cen. | | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired-Electrician | | 12b. KIND OF BUSINESS OR INDUSTRY | | 13a. STREET ADDRESS / ZIP CODE
7912 Bank Street 21224 | | |
| 13a. STATE
Md. | | 13b. COUNTY
Balto. | | 13c. CITY OR TOWN
Balto. | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Murray | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Clara Strong | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
no | | |
| 16b. SOCIAL SECURITY NO.
017-18-2499 | | 17. INFORMANT
ADDRESS
Donald Brewer 7910 Bank St. 21224 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIAC ARREST
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) PROBABLE CARDIAC ARRYTHMIA
(c) ACUTE RENAL FAILURE | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
20 MIN.
20 MIN.
1 DAY | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: PSEUDOMONAS MENINGITIS | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | |
| 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (1) this hospital attended the deceased from 11/18 , 19 86 , to 12/27 , 19 86 , that (2) the deceased was alive on 12/27 , 19 86 , and that in (my) <input checked="" type="checkbox"/> own opinion death occurred on the date and hour and from the causes stated above, (1) <input checked="" type="checkbox"/> (we) <input type="checkbox"/> did not view the body after death. | | | | | | |
| 22b. SIGNATURE
Samuel J. Hassenbusch, MD. | | DEGREE
MD. | | 22c. DATE SIGNED
12-27-86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
SAMUEL J. HASSENBUSCH | | 22e. ADDRESS
F.S. KEY MED. CENTER, BALTO, MD. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
12/30/86 | | 23c. NAME OF CEMETERY OR CREMATORY
OakLawnCemetery | | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Maryland | | 24. FUNERAL DIRECTOR
NAME ADDRESS
ConnellyFuneralHome 300MaceAve. 21221 | | | | |
| 25a. DATE REC'D. BY REGISTRAR
DEC 30 1986 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | | | |

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JAN 11 1962
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05811 1001 08

NOV 11 1961
MAIL ROOM



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner requires notification of attorney.

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | |
|--|--|--|--|---|-----------------------|--|
| 1. DECEASED NAME
FIRST MIDDLE LAST
PEARL BESSIE PARKS | | | 2a. DATE OF DEATH
MONTH DAY YEAR
DECEMBER 11, 1986 | | 2b. HOUR
4:17 P.M. | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
09 05 07 | | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
79 YRS. | | 7. UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | 8. UNDER 24 HRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
W.D.A. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY, MD. | | 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
GOOD SAMARITAN HOSPITAL | | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
K. Zimmiller | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Somers | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Carrie Wotrnie | | 16. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 17a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 17b. SOCIAL SECURITY NO.
216-38-1592 | | 17. INFORMANT
ADDRESS
FRANK PARKS Kitzmiller, Md. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>SLE and vasculitis</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u></u>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>24 hours</u>
<u>6 months</u> | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u> | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9/9/86</u> to <u>12/11/86</u> that (I) (we) lost
saw the deceased alive on <u>12/11/86</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
<u>Thomas M. Zizic</u> | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<u>12/11/86</u> | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>Thomas M. Zizic</u> | | 22e. ADDRESS
<u>5601 Loch Raven Blvd, Balt, Md 21239</u> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<u>BURIAL</u> | | 23b. DATE
<u>12-14-86</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>EGLON CEMETERY</u> | | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
<u>Eglon Preston W.D.A.</u> | | | | | | |
| 24. FUNERAL DIRECTOR
NAME
<u>David A. Byrdock</u> | | ADDRESS
<u>Kitzmillers, Md.</u> | | 25a. DATE REC'D. BY REGISTRAR
<u>DEC 17 1986</u> | | |
| 25b. REGISTRAR'S SIGNATURE
<u>Julia Davidson-Randall</u> | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| 1 - STATE REGISTRAR | | | | STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|---|--|--|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)
EDMUND THOMAS PARSON | | | | 2a. DATE OF DEATH
MONTH 12 DAY 8 YEAR 86 | | | | 2b. HOUR
14 45 M. | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH 11 DAY 22 YEAR 07 | | 6. AGE (IN YEARS LAST BIRTHDAY)
79 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New Hampshire | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Balto. City | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Garden Village | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Truck Driver | | 12b. KIND OF BUSINESS OR INDUSTRY Branch
Motor Freight | | | |
| 13a. STATE
Md. | | 13b. COUNTY | | 13c. CITY OR TOWN
Balto. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
4117 Mary Ave. Balto., Md. 21206 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Edmund Parson | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Dorothea Chilcote | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
218-01-1281 | | 17. INFORMANT ADDRESS
Virginia Parson (wife) same address | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cancer metastatic</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>rich signs</u>
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____ | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Chung C. Ng M.D.</u> | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
12/11/86 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS
5907 Bel Air Rd. Balto., Md. 21206 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
12/11/86 | | 23c. NAME OF CEMETERY OR CREMATORY
Gardens of Faith | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Md. | | | |
| 24. FUNERAL DIRECTOR'S NAME
SCHIMUNEK FUNERAL HOME, INC.
3331 Brehms Lane, Balto. Md. 21213 | | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 11 1986 | | 25b. REGISTRAR'S SIGNATURE
<u>Frederick P. Jones</u> | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2, and file them with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|---|---|----------------------------|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) DORA PARSONS | | | 2a. DATE OF DEATH
MONTH 12 DAY 20 YEAR 1986 | | 2b. HOUR
6:45P M | | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH 08 DAY 13 YEAR 1912 | | 6. AGE (IN YEARS LAST BIRTHDAY)
74 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
St. Agnes Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Supervisor | | 12b. KIND OF BUSINESS OR INDUSTRY
Md. Glass | |
| 13a. STATE
Maryland | | 13b. COUNTY
--- | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST Julin MIDDLE Claybrook LAST Rowley | | 15. MOTHER'S MAIDEN NAME
FIRST Lula MIDDLE Blanche LAST Covington | | 13e. STREET ADDRESS / ZIP CODE
2015 Whistler Avenue, 21230 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
--- | | 17. INFORMANT
ADDRESS
Patricia L. Litchfield, 408 Bathurst Road | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Heart Failure
DUE TO, OR AS A CONSEQUENCE OF
(b) Cor Pulmonale
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c) --- | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
Chronic obstructive pulmonary disease Anasarca | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Dec 1 19 86 , to Dec 20 19 86 , that (I) (we) lost saw the deceased alive on Dec 20 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Gonzalo F. Urbano | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Gonzalo F. Urbano | | | | 22e. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
12/23/86 | | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Maryland | |
| 24. FUNERAL DIRECTOR
NAME
Hubbard Funeral Home, Inc., | | | | ADDRESS
4107 Wilkens Ave. | | 25a. DATE REC'D. BY REGISTRAR
DEC 22 1986 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
John R. ... | | | |

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1865-1866

| 1865 | | 1866 | | 1867 | | 1868 | | 1869 | | 1870 | | 1871 | | 1872 | | 1873 | | 1874 | | 1875 | | 1876 | | 1877 | | 1878 | | 1879 | | 1880 | | 1881 | | 1882 | | 1883 | | 1884 | | 1885 | | 1886 | | 1887 | | 1888 | | 1889 | | 1890 | | 1891 | | 1892 | | 1893 | | 1894 | | 1895 | | 1896 | | 1897 | | 1898 | | 1899 | | 1900 | | 1901 | | 1902 | | 1903 | | 1904 | | 1905 | | 1906 | | 1907 | | 1908 | | 1909 | | 1910 | | 1911 | | 1912 | | 1913 | | 1914 | | 1915 | | 1916 | | 1917 | | 1918 | | 1919 | | 1920 | | 1921 | | 1922 | | 1923 | | 1924 | | 1925 | | 1926 | | 1927 | | 1928 | | 1929 | | 1930 | | 1931 | | 1932 | | 1933 | | 1934 | | 1935 | | 1936 | | 1937 | | 1938 | | 1939 | | 1940 | | 1941 | | 1942 | | 1943 | | 1944 | | 1945 | | 1946 | | 1947 | | 1948 | | 1949 | | 1950 | | 1951 | | 1952 | | 1953 | | 1954 | | 1955 | | 1956 | | 1957 | | 1958 | | 1959 | | 1960 | | 1961 | | 1962 | | 1963 | | 1964 | | 1965 | | 1966 | | 1967 | | 1968 | | 1969 | | 1970 | | 1971 | | 1972 | | 1973 | | 1974 | | 1975 | | 1976 | | 1977 | | 1978 | | 1979 | | 1980 | | 1981 | | 1982 | | 1983 | | 1984 | | 1985 | | 1986 | | 1987 | | 1988 | | 1989 | | 1990 | | 1991 | | 1992 | | 1993 | | 1994 | | 1995 | | 1996 | | 1997 | | 1998 | | 1999 | | 2000 | | 2001 | | 2002 | | 2003 | | 2004 | | 2005 | | 2006 | | 2007 | | 2008 | | 2009 | | 2010 | | 2011 | | 2012 | | 2013 | | 2014 | | 2015 | | 2016 | | 2017 | | 2018 | | 2019 | | 2020 | | 2021 | | 2022 | | 2023 | | 2024 | | 2025 | | 2026 | | 2027 | | 2028 | | 2029 | | 2030 | | 2031 | | 2032 | | 2033 | | 2034 | | 2035 | | 2036 | | 2037 | | 2038 | | 2039 | | 2040 | | 2041 | | 2042 | | 2043 | | 2044 | | 2045 | | 2046 | | 2047 | | 2048 | | 2049 | | 2050 | | 2051 | | 2052 | | 2053 | | 2054 | | 2055 | | 2056 | | 2057 | | 2058 | | 2059 | | 2060 | | 2061 | | 2062 | | 2063 | | 2064 | | 2065 | | 2066 | | 2067 | | 2068 | | 2069 | | 2070 | | 2071 | | 2072 | | 2073 | | 2074 | | 2075 | | 2076 | | 2077 | | 2078 | | 2079 | | 2080 | | 2081 | | 2082 | | 2083 | | 2084 | | 2085 | | 2086 | | 2087 | | 2088 | | 2089 | | 2090 | | 2091 | | 2092 | | 2093 | | 2094 | | 2095 | | 2096 | | 2097 | | 2098 | | 2099 | | 2100 | | 2101 | | 2102 | | 2103 | | 2104 | | 2105 | | 2106 | | 2107 | | 2108 | | 2109 | | 2110 | | 2111 | | 2112 | | 2113 | | 2114 | | 2115 | | 2116 | | 2117 | | 2118 | | 2119 | | 2120 | | 2121 | | 2122 | | 2123 | | 2124 | | 2125 | | 2126 | | 2127 | | 2128 | | 2129 | | 2130 | | 2131 | | 2132 | | 2133 | | 2134 | | 2135 | | 2136 | | 2137 | | 2138 | | 2139 | | 2140 | | 2141 | | 2142 | | 2143 | | 2144 | | 2145 | | 2146 | | 2147 | | 2148 | | 2149 | | 2150 | | 2151 | | 2152 | | 2153 | | 2154 | | 2155 | | 2156 | | 2157 | | 2158 | | 2159 | | 2160 | | 2161 | | 2162 | | 2163 | | 2164 | | 2165 | | 2166 | | 2167 | | 2168 | | 2169 | | 2170 | | 2171 | | 2172 | | 2173 | | 2174 | | 2175 | | 2176 | | 2177 | | 2178 | | 2179 | | 2180 | | 2181 | | 2182 | | 2183 | | 2184 | | 2185 | | 2186 | | 2187 | | 2188 | | 2189 | | 2190 | | 2191 | | 2192 | | 2193 | | 2194 | | 2195 | | 2196 | | 2197 | | 2198 | | 2199 | | 2200 | | 2201 | | 2202 | | 2203 | | 2204 | | 2205 | | 2206 | | 2207 | | 2208 | | 2209 | | 2210 | | 2211 | | 2212 | | 2213 | | 2214 | | 2215 | | 2216 | | 2217 | | 2218 | | 2219 | | 2220 | | 2221 | | 2222 | | 2223 | | 2224 | | 2225 | | 2226 | | 2227 | | 2228 | | 2229 | | 2230 | | 2231 | | 2232 | | 2233 | | 2234 | | 2235 | | 2236 | | 2237 | | 2238 | | 2239 | | 2240 | | 2241 | | 2242 | | 2243 | | 2244 | | 2245 | | 2246 | | 2247 | | 2248 | | 2249 | | 2250 | | 2251 | | 2252 | | 2253 | | 2254 | | 2255 | | 2256 | | 2257 | | 2258 | | 2259 | | 2260 | | 2261 | | 2262 | | 2263 | | 2264 | | 2265 | | 2266 | | 2267 | | 2268 | | 2269 | | 2270 | | 2271 | | 2272 | | 2273 | | 2274 | | 2275 | | 2276 | | 2277 | | 2278 | | 2279 | | 2280 | | 2281 | | 2282 | | 2283 | | 2284 | | 2285 | | 2286 | | 2287 | | 2288 | | 2289 | | 2290 | | 2291 | | 2292 | | 2293 | | 2294 | | 2295 | | 2296 | | 2297 | | 2298 | | 2299 | | 2300 | | 2301 | | 2302 | | 2303 | | 2304 | | 2305 | | 2306 | | 2307 | | 2308 | | 2309 | | 2310 | | 2311 | | 2312 | | 2313 | | 2314 | | 2315 | | 2316 | | 2317 | | 2318 | | 2319 | | 2320 | | 2321 | | 2322 | | 2323 | | 2324 | | 2325 | | 2326 | | 2327 | | 2328 | | 2329 | | 2330 | | 2331 | | 2332 | | 2333 | | 2334 | | 2335 | | 2336 | | 2337 | | 2338 | | 2339 | | 2340 | | 2341 | | 2342 | | 2343 | | 2344 | | 2345 | | 2346 | | 2347 | | 2348 | | 2349 | | 2350 | | 2351 | | 2352 | | 2353 | | 2354 | | 2355 | | 2356 | | 2357 | | 2358 | | 2359 | | 2360 | | 2361 | | 2362 | | 2363 | | 2364 | | 2365 | | 2366 | | 2367 | | 2368 | | 2369 | | 2370 | | 2371 | | 2372 | | 2373 | | 2374 | | 2375 | | 2376 | | 2377 | | 2378 | | 2379 | | 2380 | | 2381 | | 2382 | | 2383 | | 2384 | | 2385 | | 2386 | | 2387 | | 2388 | | 2389 | | 2390 | | 2391 | | 2392 | | 2393 | | 2394 | | 2395 | | 2396 | | 2397 | | 2398 | | 2399 | | 2400 | | 2401 | | 2402 | | 2403 | | 2404 | | 2405 | | 2406 | | 2407 | | 2408 | | 2409 | | 2410 | | 2411 | | 2412 | | 2413 | | 2414 | | 2415 | | 2416 | | 2417 | | 2418 | | 2419 | | 2420 | | 2421 | | 2422 | | 2423 | | 2424 | | 2425 | | 2426 | | 2427 | | 2428 | | 2429 | | 2430 | | 2431 | | 2432 | | 2433 | | 2434 | | 2435 | | 2436 | | 2437 | | 2438 | | 2439 | | 2440 | | 2441 | | 2442 | | 2443 | | 2444 | | 2445 | | 2446 | | 2447 | | 2448 | | 2449 | | 2450 | | 2451 | | 2452 | | 2453 | | 2454 | | 2455 | | 2456 | | 2457 | | 2458 | | 2459 | | 2460 | | 2461 | | 2462 | | 2463 | | 2464 | | 2465 | | 2466 | | 2467 | | 2468 | | 2469 | | 2470 | | 2471 | | 2472 | | 2473 | | 2474 | | 2475 | | 2476 | | 2477 | | 2478 | | 2479 | | 2480 | | 2481 | | 2482 | | 2483 | | 2484 | | 2485 | | 2486 | | 2487 | | 2488 | | 2489 | | 2490 | | 2491 | | 2492 | | 2493 | | 2494 | | 2495 | | 2496 | | 2497 | | 2498 | | 2499 | | 2500 | | 2501 | | 2502 | | 2503 | | 2504 | | 2505 | | 2506 | | 2507 | | 2508 | | 2509 | | 2510 | | 2511 | | 2512 | | 2513 | | 2514 | | 2515 | | 2516 | | 2517 | | 2518 | | 2519 | | 2520 | | 2521 | | 2522 | | 2523 | | 2524 | | 2525 | | 2526 | | 2527 | | 2528 | | 2529 | | 2530 | | 2531 | | 2532 | | 2533 | | 2534 | | 2535 | | 2536 | | 2537 | | 2538 | | 2539 | | 2540 | | 2541 | | 2542 | | 2543 | | 2544 | | 2545 | | 2546 | | 2547 | | 2548 | | 2549 | | 2550 | | 2551 | | 2552 | | 2553 | | 2554 | | 2555 | | 2556 | | 2557 | | 2558 | | 2559 | | 2560 | | 2561 | | 2562 | | 2563 | | 2564 | | 2565 | | 2566 | | 2567 | | 2568 | | 2569 | | 2570 | | 2571 | | 2572 | | 2573 | | 2574 | | 2575 | | 2576 | | 2577 | | 2578 | | 2579 | | 2580 | | 2581 | | 2582 | | 2583 | | 2584 | | 2585 | | 2586 | | 2587 | | 2588 | | 2589 | | 2590 | | 2591 | | 2592 | | 2593 | | 2594 | | 2595 | | 2596 | | 2597 | | 2598 | | 2599 | | 2600 | | 2601 | | 2602 | | 2603 | | 2604 | | 2605 | | 2606 | | 2607 | | 2608 | | 2609 | | 2610 | | 2611 | | 2612 | | 2613 | | 2614 | | 2615 | | 2616 | | 2617 | | 2618 | | 2619 | | 2620 | | 2621 | | 2622 | | 2623 | | 2624 | | 2625 | | 2626 | | 2627 | | 2628 | | 2629 | | 2630 | | 2631 | | 2632 | | 2633 | | 2634 | | 2635 | | 2636 | | 2637 | | 2638 | | 2639 | | 2640 | | 2641 | | 2642 | | 2643 | | 2644 | | 2645 | | 2646 | | 2647 | | 2648 | | 2649 | | 2650 | | 2651 | | 2652 | | 2653 | | 2654 | | 2655 | | 2656 | | 2657 | | 2658 | | 2659 | | 2660 | | 2661 | | 2662 | | 2663 | | 2664 | | 2665 | | 2666 | | 2667 | | 2668 | | 2669 | | 2670 | | 2671 | | 2672 | | 2673 | | 2674 | | 2675 | | 2676 | | 2677 | | 2678 | | 2679 | | 2680 | | 2681 | | 2682 | | 2683 | | 2684 | | 2685 | | 2686 | | 2687 | | 2688 | | 2689 | | 2690 | | 2691 | | 2692 | | 2693 | | 2694 | | 2695 | | 2696 | | 2697 | | 2698 | | 2699 | | 2700 | | 2701 | | 2702 | | 2703 | | 2704 | | 2705 | | 2706 | | 2707 | | 2708 | | 2709 | | 2710 | | 2711 | | 2712 | | 2713 | | 2714 | | 2715 | | 2716 | | 2717 | | 2718 | | 2719 | | 2720 | | 2721 | | 2722 | | 2723 | | 2724 | | 2725 | | 2726 | | 2727 | | 2728 | | 2729 | | 2730 | | 2731 | | 2732 | | 2733 | | 2734 | | 2735 | | 2736 | | 2737 | | 2738 | | 2739 | | 2740 | | 2741 | | 2742 | | 2743 | | 2744 | | 2745 | | 2746 | | 2747 | | 2748 | | 2749 | | 2750 | | 2751 | | 2752 | | 2753 | | 2754 | | 2755 | | 2756 | | 2757 | | 2758 | | 2759 | | 2760 | | 2761 | | 2762 | | 2763 | | 2764 | | 2765 | | 2766 | | 2767 | | 2768 | | 2769 | | 2770 | | 2771 | | 2772 | | 2773 | | 2774 | | 2775 | | 2776 | | 2777 | | 2778 | | 2779 | | 2780 | | 2781 | | 2782 | | 2783 | | 2784 | | 2785 | | 2786 | | 2787 | | 2788 | | 2789 | | 2790 | | 2791 | | 2792 | | 2793 | | 2794 | | 2795 | | 2796 | | 2797 | | 2798 | | 2799 | | 2800 | | 2801 | | 2802 | | 2803 | | 2804 | | 2805 | | 2806 | | 2807 | | 2808 | | 2809 | | 2810 | | 2811 | | 2812 | | 2813 | | 2814 | | 2815 | | 2816 | | 2817 | | 2818 | | 2819 | | 2820 | | 2821 | | 2822 | | 2823 | | 2824 | | 2825 | | 2826 | | 2827 | | 2828 | | 2829 | | 2830 | | 2831 | | 2832 | | 2833 | | 2834 | | 2835 | | 2836 | | 2837 | | 2838 | | 2839 | | 2840 | | 2841 | | 2842 | | 2843 | | 2844 | | 2845 | | 2846 | | 2847 | | 2848 | | 2849 | | 2850 | | 2851 | | 2852 | | 2853 | | 2854 | | 2855 | | 2856 | | 2857 | | 2858 | | 2859 | | 2860 | | 2861 | | 2862 | | 2863 | | 2864 | | 2865 | | 2866 | | 2867 | | 2868 | | 2869 | | 2870 | | 2871 | | 2872 | | 2873 | | 2874 | | 2875 | | 2876 | | 2877 | | 2878 | | 2879 | | 2880 | | 2881 | | 2882 | | 2883 | | 2884 | | 2885 | | 2886 | | 2887 | | 2888 | | 2889 | | 2890 | | 2891 | | 2892 | | 2893 | | 2894 | | 2895 | | 289 | |
|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | |
|---|---|---|------------------------------------|---|--|--|
| 1. FOR STATE REGISTRAR
DECEASED NAME
(TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH
MONTH DAY YEAR | 2b. HOUR |
| Susie A. | | | | Patterson | 12-11-86 | 11:30 PM |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH
MONTH DAY YEAR | | 6. AGE
(IN YEARS LAST BIRTHDAY) | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| F | BLACK | 12 th 31 19 th | | 67 | | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| N.C. | USA | | | Baltimore City MD. | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Baltimore | Union Memorial Hospital | | | UNEMP. | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE | |
| MD | | BALTO. | | | 1769 MONTEPELIER 21228 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | | | |
| UNK | | UNK | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES) | | 17. INFORMANT ADDRESS | | |
| NO | | ? | | HESTER TILLERY 1611 ARGONE DR. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiac Standstill</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Brainstem Herniation</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) <u>CVA</u> | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12-10</u> , 19 <u>86</u> , to <u>12-11</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>12-11</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE
<u>Domingo Rocha Jr</u> | | DEGREE
M.D. | | 22c. DATE SIGNED
<u>12/11/86</u> |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | |
| Domingo Rocha Jr | | Union Memorial Hospital | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SREC#) | | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | |
| BURIAL | | 12-17-86 | MT. ZION CEMETERY | | BALTO., MD | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| MARCH FUNERAL HOME 1101 E. NORTH AVE. | | | DEC 16 1986 | | Lila Davidson-Randall | |

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Unit 1

Unit 1

Unit 1

Unit 1

Unit 1

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

SWAIN

T,

PATTERSON

2a. DATE OF DEATH

MONTH

DAY

YEAR

2b. HOUR P

DECEMBER 26

1986

4:40 M

3. SEX

Male

4. RACE

Black

5. DATE OF BIRTH

MONTH

DAY

YEAR

0

4

66

6. AGE (IN YEARS LAST BIRTHDAY)

IF UNDER 1 YEAR

IF UNDER 24 HRS

20

YRS.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Maryland

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

BALTIMORE CITY

MD.

10. CITY OR TOWN OF DEATH

BALTIMORE

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

THE JOHNS HOPKINS HOSPITAL

12a. USUAL OCCUPATION

(TYPE OF WORK FOR MOST OF WORKING LIFE)

Cashier

12b. KIND OF BUSINESS OR INDUSTRY

-

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Maryland

13b. COUNTY

Baltimore

13c. CITY OR TOWN

Baltimore

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE

523 N. Fulton Ave #23

14. FATHER'S NAME

Nathaniel

MIDDLE

Wilson

LAST

15. MOTHER'S MAIDEN NAME

Emma

MIDDLE

J.

Patterson

LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

(YES, NO OR UNKNOWN)

no

(IF YES, GIVE WAR OR DATES)

-

16b. SOCIAL SECURITY NO.

216-94-2057

17. INFORMANT

ADDRESS

Emma J. Patterson 523 N. Fulton Ave. #23

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

RESPIRATORY ARREST

APPROXIMATE INTERVAL

BETWEEN ONSET AND DEATH

20 minutes

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

AIDS ENCEPHALOPATHY

2-3 months

DUE TO, OR AS A CONSEQUENCE OF

(c)

Human immune deficiency virus infection

2-3 years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED

IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING

OR CONTRIBUTING ☐ CAUSE OF DEATH

(IF EITHER NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)

21d. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY

(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from 12/24, 19 86, to 12/26, 19 86, that (I) (we) last

saw the deceased alive on 12/26, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated

above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

Kevin Horgan

DEGREE

MD

ATTENDING

PHYSICIAN

MEDICAL

DIRECTOR ☒

STAFF

PHYSICIAN ☐

22c. DATE SIGNED

12/26/86

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

Kevin Horgan

22e. ADDRESS

% Johns Hopkins Hospital

23a. BURIAL, CREMATION, REMOVAL

(SPECIFY)

Burial

23b. DATE

12/31/86

23c. NAME OF CEMETERY OR CREMATORY

Cedar Hill Cem.

23d. LOCATION

CITY OR TOWN

Glenburnie

COUNTY

STATE

Md.

24. FUNERAL DIRECTOR

NAME

March Funeral Home

ADDRESS

4300 Wabash Ave.

25. DATE REC'D. BY REGISTRAR

DEC 30 1986

26. REGISTRAR'S SIGNATURE

Julia Steiner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The place for the funeral director's signature is on page 3.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



028432 DEC 30 1986

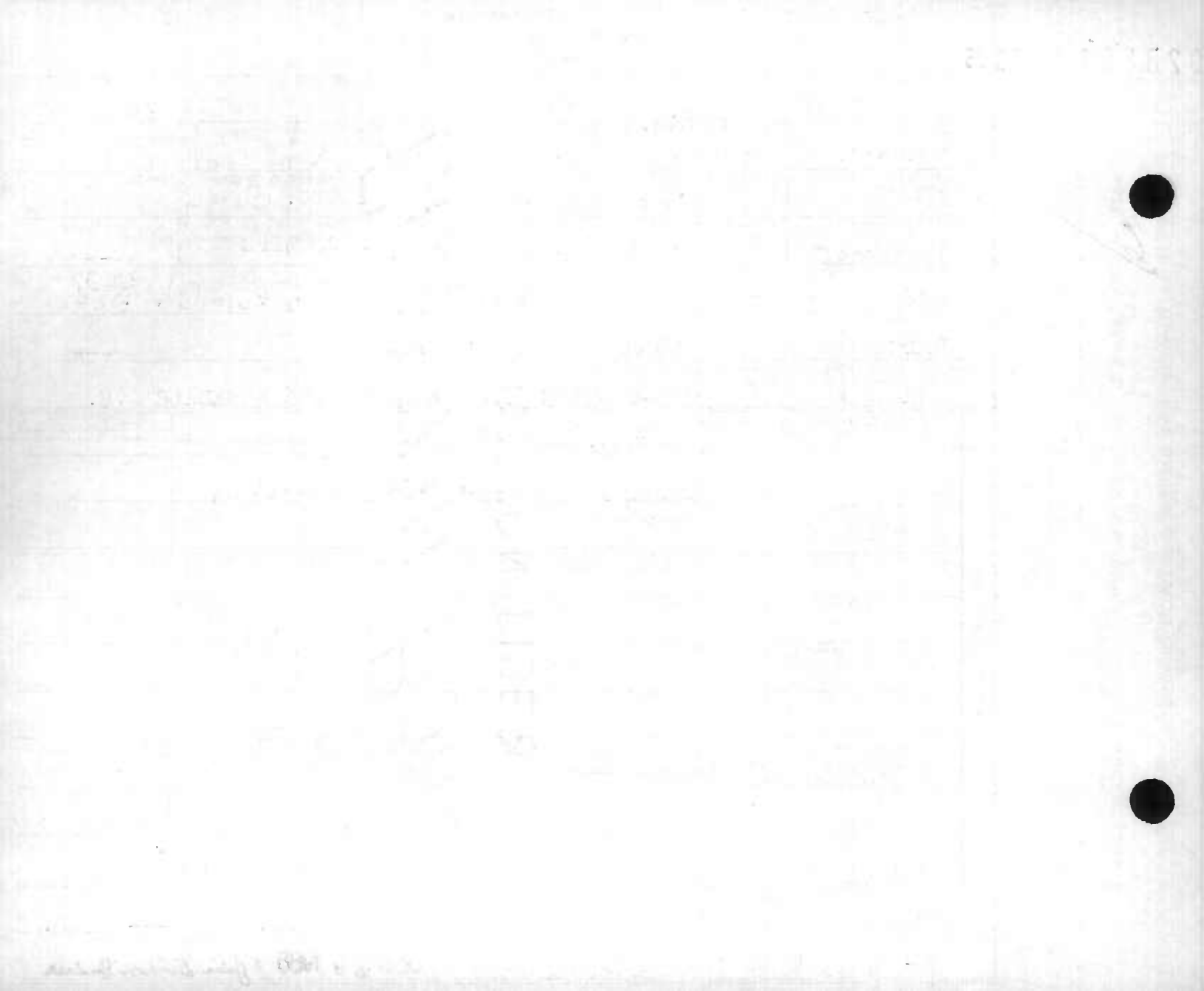
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| MARY BARBARA PANUSKA | | | | STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | |
|--|--|--|--|---|--|---|--|
| FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE B. LAST Panuska | | | | 2a. DATE OF DEATH MONTH 12 DAY 25 YEAR 86 | | 2b. HOUR 10:30 ^{AM} | |
| 3 SEX Female | | 4 RACE CAUCAS. white | | 5. DATE OF BIRTH 04/10/05 MONTH 04 DAY 10 YEAR 05 | | 6 AGE (IN YEARS LAST BIRTHDAY) 81 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. city MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FSK Medical Ctr | | 12a. USUAL OCCUPATION (IF NOT IN SUCH FACILITY, GIVE WORKING LIFE) HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Md | | | | 13b. COUNTY Balt | | 13c. CITY OR TOWN Balt | |
| 14. FATHER'S NAME FIRST JOSEPH MIDDLE LAST KUDRNA | | | | 15. MOTHER'S MAIDEN NAME FIRST BARBARA MIDDLE LAST --- | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 213-01-0483 | | 17. INFORMANT ADDRESS MARIAN LEVY 946 ROSEDALE AVE. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiogenic shock
DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial infarction
DUE TO, OR AS A CONSEQUENCE OF (c) ---
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12-18, 1986, to 12-19, 1986, that (I) (we) last saw the deceased alive on 12-23, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 12-25-86 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Howard S. Toch | | | | 22e. ADDRESS FSK Medical Ctr | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 12/29/86 | | 23c. NAME OF CEMETERY OR CREMATORY HOLY REDEEMER | | 23d. LOCATION CITY OR TOWN BALTO. COUNTY STATE MD. | |
| 24. FUNERAL DIRECTOR (NAME) John S. ... | | | | 25a. DATE REC'D. BY REGISTRAR DEC 29 1986 | | 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall | |



027842 DEC 23 1986

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

2- DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Thomas

H.

Payne

2b. DATE KNOWN OF DEATH
☒ MONTH ☐ DAY ☐ YEAR
12/ 14/ 19 86

2b. HOUR
M

3. SEX

MALE

4. RACE

BLACK

5. DATE OF BIRTH

3

28

20

6. AGE (IN YEARS)

66

7. IF UNDER 1 YR.

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

2c. DATE

12/ 14/ 19 86

2d. HOUR

1:55

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

VA

7b. CITIZEN OF WHAT COUNTRY?

USA

9. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore City,

MD.

10. CITY OR TOWN OF DEATH

Baltimore

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION

1045 W. Mulberry St.

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

UNK

12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

MD

13b. COUNTY

13c. CITY OR TOWN

BALTO

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS

1045 W MULBERRY ST. 21223

14. FATHER'S NAME

ROBERT

MIDDLE

LAST

PAYNE

15. MOTHER'S MAIDEN NAME

IDA

MIDDLE

LAST

BAYLOR

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

NO

(YES, NO, OR UNKNOWN)

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.

UNK

17. INFORMANT

ADDRESS

DELTA BARGEMAN 330 RHODE IS AVE

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.

(b) DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

Chronic Obstructive Pulmonary Disease

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS

UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐
AT WORK AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that I took charge of the remains described above, held on Autopsy ☐ Inspection ☒ Inquiry ☐ and in my opiniondeath resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

TITLE (SPECIFY)

M.D. Assistant MEDICAL EXAMINER

DATE SIGNED 12/15/86

ACTUAL SIGNATURE

EXAMINER'S NAME (TYPE OR PRINT)

Gregory R. Kauffman, M.D. ADDRESS 111 Penn St.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

BURIAL

23b. DATE

12 20 86

23c. NAME OF CEMETERY OR CREMATORY

EASTVIEW MEMORIAL

23d. LOCATION CITY OR TOWN

BALTO

COUNTY

STATE

MD

24. FUNERAL DIRECTOR NAME

ADDRESS

MARCH FUNERAL HOME 1101 E. NORTH AVE

25a. DATE REC'D. BY REGISTRAR

DEC 19 1986

25b. REGISTRAR'S SIGNATURE

John D. ...

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

WILLIAM
WILLIAM
WILLIAM



1027969 DEC 23 1986

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

34870

| | | | | | | | | | | | |
|---|--|---|--|---|--------|--|---|---|---|---|--|
| FOR
STATE
REGISTRAR | | 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST
VALLEY | MIDDLE | LAST
PEAY | 2a. DATE OF DEATH
MONTH DAY YEAR
12 12 86 | | 2b. HOUR
12:50 AM | | |
| 3. SEX
F | | 4. RACE
B | | 5. DATE OF BIRTH
MONTH DAY YEAR
12 4 24 | | 6. AGE (IN YEARS LAST BIRTHDAY)
62 YRS | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
UNKNOWN | | 7b. CITIZEN OF WHAT COUNTRY?
US | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY, MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SOUTH BALT. GEN. HOSP. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOME MAKER | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13a. STATE
MD | | 13b. COUNTY
BALT. | | 13c. CITY OR TOWN
BALT. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
JACK | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
BEATRICE Samuel UNKNOWN | | | | 13e. STREET ADDRESS / ZIP CODE
2850 ROUND RD, 21225 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
UNK | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
247-38-3606 | | 17. INFORMANT
ADDRESS
Johnnie Peay 2850 Round Rd. 21225 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST
DUE TO, OR AS A CONSEQUENCE OF
(b) MASSIVE INTRACEREBRAL BLEED. 1 DAY.
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK
NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost
saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
G. Weiss | | | | DEGREE
MD | | | | 22c. DATE SIGNED
12/12/86 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
G. WEISS | |
| 22e. ADDRESS
3001 S. HANOVER ST., BALT., MD. | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
SPECIFY
Burial | | 23b. DATE
12/17/86 | | 23c. NAME OF CEMETERY OR CREMATORY
Md. Veterans Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Crownsville Md. | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Chas. A. Rice FSPA 1300 Eutaw Place | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 19 1986 | | 25b. REGISTRAR'S SIGNATURE | | | | | |

34810

053



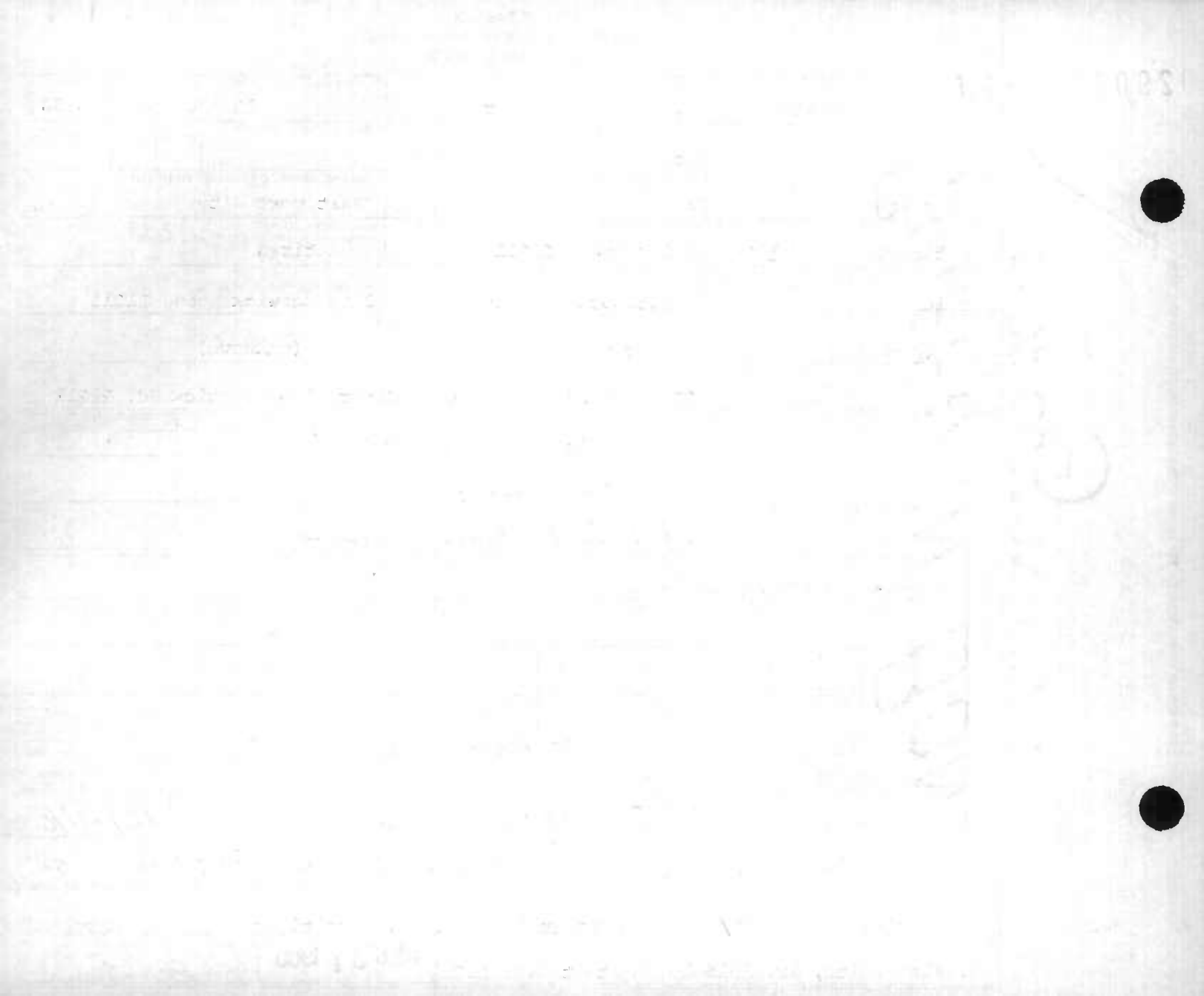
34810

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | |
|--|--|--|---|---|-------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Bessie I. Peddicord | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 30 86 | | 2b. HOUR
P M
8:30 | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
09 16 1893 | | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
93 YRS. | | 7. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
3029 Keswick Road 21211 | | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | | 12b. KIND OF BUSINESS OR INDUSTRY | | 13. STREET ADDRESS / ZIP CODE
3029 Keswick Road 21211 | | |
| 13a. STATE
Maryland | | 13b. COUNTY
-- | | 13c. CITY OR TOWN
Baltimore | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
(unknown) -- Gordon | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
(unknown) -- | | 16. SOCIAL SECURITY NO.
220-05-3915 | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No -- | | 16b. SOCIAL SECURITY NO.
220-05-3915 | | 17. INFORMANT
ADDRESS
Maynard Peddicord 3604 Keswick Rd. 21211 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest.</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>congestive heart failure</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>atherosclerotic heart disease.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)
<u>Mitral regurgitation.</u> | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF FIFTH, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED
(ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>December</u> , 19 <u>86</u> , to <u>12/31/86</u> , that (I) (we) lost
saw the deceased alive on <u>12/31/86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
<u>Milan Winter</u> | | DEGREE
MD. | | 22c. DATE SIGNED
12/31/86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MILAN WINTER | | 22e. ADDRESS
2435 West Belvedere Ave; Baltimore, MD 21211 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
1/3/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Meadowridge Mem. Pk. | | |
| 23d. LOCATION
CITY OR TOWN
Baltimore | | 23e. COUNTY
Maryland | | 23f. STATE
Maryland | | |
| 24. FUNERAL DIRECTOR
NAME
A. Alan Seitz, Jr. | | ADDRESS
3615-19 Chestnut Ave. 21211 | | 25. DATE REC'D. BY REGISTRAR
DEC 31 1986 | | |
| 25. REGISTRAR'S SIGNATURE
Julia Seitz-Randall | | | | | | |

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | |
|---|--|--|--|---|--|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Charles PELLETIER | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 8 86 | | | 2b. HOUR
9:00A M | | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
June 18 15 | | 6. AGE (IN YEARS LAST BIRTHDAY)
71 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Wisconsin | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
401 Yale Avenue | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Electrician Asst. | | 12b. KIND OF BUSINESS OR INDUSTRY
Electrical | | |
| 13a. STATE
Maryland | | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
401 Yale Avenue, 21229 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
UNKNOWN | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
UNKNOWN | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
--- | | 17. INFORMANT
ADDRESS
Mary Conover, 601 Maiden Choice Lane | | | 21228 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Ischemic Heart Disease, Angina
DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial Infarction,
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }
DUE TO, OR AS A CONSEQUENCE OF (c) Hypothyroidism,
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
(Signature) | | | | | DEGREE | | 22c. DATE SIGNED
12/9/86 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
(TRADEEP GARG) | | | | | 22e. ADDRESS
St Agnes Hospital, Baltimore | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
12/12/86 | | 23c. NAME OF CEMETERY OR CREMATORY
New Cathedral Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Maryland | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Hubbard Funeral Home, Inc., 4107 Wilkens Ave. | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 10 1986 | | 25b. REGISTRAR'S SIGNATURE
(Signature) | | | |

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MEDICAL CERTIFICATION

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please return the completed pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|--|---|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Edward King Pembroke III | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 31 86 | | 2b. HOUR
9:08 PM |
| 3. SEX
Male | 4. RACE
Black | 5. DATE OF BIRTH
MONTH DAY YEAR
11 22 40 | 6. AGE (LAST BIRTHDAY)
46 YRS | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Balto, MD | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Balto City MD | | |
| 10. CITY OR TOWN OF DEATH
Balto | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Univ MD Hosp. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
- | | 12b. KIND OF BUSINESS
INDUSTRY
- |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MD | | | 13b. COUNTY
Balto | 13c. CITY OR TOWN
Balto | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Edward Pembroke, Jr. | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Bernice William | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
220 360086 | 17. INFORMANT
ADDRESS
Bernice Pembroke 1125 N Longwood | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>massive bleed.</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Chronic myelogenous leukemia</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/31</u> 19 <u>86</u> , to <u>12/31</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>12/31</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>[Signature]</u> | | DEGREE
MD | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
AUSTIN MA | | 22e. ADDRESS
Univ MD Hosp 22 S. Green, Balto MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL
Burial | | 23b. DATE
1/3/87 | 23c. NAME OF CEMETERY OR CREMATORY
King Memorial Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Randletstown Md. |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
W.C. March F.H. 4300 Wabash Ave. | | | 25a. DATE REC'D. BY REGISTRAR
JAN 5 1987 | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> |

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

10-11-1983



10-11-1983

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | REG. NO. | |
|---|--|---|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Sallie H. Pembroke | | | 2a. DATE OF DEATH
MONTH DAY YEAR 12/13/86 | | 2b. HOUR
5⁵⁹ P.M. | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR 06 28 10 | | 6. AGE (IN YEARS LAST BIRTHDAY)
76 YRS. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
N.C. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNION MEMORIAL HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
Md. | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
- Satterwhite | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Camilla - | | 13e. STREET ADDRESS / ZIP CODE
4000 Hamilton Ave. 21206 | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
217-20-9013 | | 17. INFORMANT ADDRESS
Mr. David Pembroke Same | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) cardiorespiratory arrest
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) electromechanical dissociation
DUE TO, OR AS A CONSEQUENCE OF (c) oat cell carcinoma | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a
none | | | | | | |
| 19a. DATE OF OPERATION
bronchoscopy 12/11/86 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
oat cell carcinoma | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/9 19 86 to 12/13 19 86 , that (I) (we) last saw the deceased alive on 12/13 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
C. marco MD | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
12/13/86 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MARCO | | 22e. ADDRESS
UMH | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
Dec. 17, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Md. |
| 24. FUNERAL DIRECTOR
Leonard J. Ruck Inc. Baltimore, Maryland | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 15 1986 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall |

15/12/23

Dear Sir,

I have the pleasure to acknowledge the receipt of your letter of the 14th inst. in relation to the above matter.

I am sorry to hear that you are experiencing difficulties with the system. I will ensure that the relevant departments are kept informed of the situation.

I will be in contact with you again once a resolution has been reached.

Yours faithfully,

[Signature]

Mr. J. Smith

026192 DEC

STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | |
|---|--|--|--|---|----------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Eugene L. Pessagno JR. | | | 2a. DATE OF DEATH
MONTH DAY YEAR
December 1, 1986 | | 2b. HOUR
3:10 PM | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
May 30, 1911 | | |
| 6. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | | 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Maryland General Hospital | | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Doctor | | 12b. KIND OF BUSINESS OR INDUSTRY
Dental | | 13a. STREET ADDRESS / ZIP CODE
2001 Edmondson Avenue 21228 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Eugene Pessagno Sr. | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Margaret Eyerly | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | |
| 16b. SOCIAL SECURITY NO.
WW II | | 17. INFORMANT
Mary Pessagno | | ADDRESS
Same as # 13 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) Prostatic Carcinoma, Metastatic
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Gross Dehydration | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | |
| 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | 22a. I certify that (X) this hospital attended the deceased from November 30, 1986 to December 1, 1986 that (X) (we) lost
saw the deceased alive on December 1, 1986 , and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated
above, (XX) (we) (did) (do) (XXX) view the body after death. | | | | |
| 22b. SIGNATURE
D. Mathews | | DEGREE
DI MATHEWS | | 22c. DATE SIGNED
12/1/86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DI MATHEWS | | 22e. ADDRESS
Baltimore, Maryland
c/o Maryland General Hospital | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Entombment | | 23b. DATE
12/5/86 | | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park Mausoleum | | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Maryland | | 24. FUNERAL DIRECTOR
Leroy M. & Russell C. Witzke Funeral Homes P.A. | | 25a. DATE REC'D. BY REGISTRAR
DEC 4 1986 | | |
| 25b. REGISTRAR'S SIGNATURE
Alan Gordon-Randall | | 26. ADDRESS
1630 Edmondson Avenue, Catonsville, MD. 21228 | | | | |

MEDICAL CERTIFICATION

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28463 DEC 30

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|--|--|---|--|---|--|--|---|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Charles L. Peterson | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 25 1986 | | | 2b. HOUR
10:30pm | | | | | |
| 3. SEX
Male | | 4. RACE
Cauc. | | 5. DATE OF BIRTH
MONTH DAY YEAR
5 3 1920 | | 6. AGE (IN YEARS LAST BIRTHDAY)
66 YRS | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
32 N. Streeper St. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Truckdreiver | | 12b. KIND OF BUSINESS OR INDUSTRY
Service | | | |
| 13a. STATE
Md. | | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
32 N. Streeper St. 21224 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Herman Peterson | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Dorothy Schmitt | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
219-05-6751 | |
| 17. INFORMANT
ADDRESS
Elizabeth Rappold 7910 33rd St. | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>COPD</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(c) <u>Hypertension</u>
DUE TO, OR AS A CONSEQUENCE OF
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>16</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Sept</u> , 19 <u>78</u> , to <u>Dec</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>Dec</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22a. SIGNATURE
<u>Dorothy A. Ordover-Smith MD</u> | | | DEGREE
<u>MD</u> | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
<u>12-28-86</u> | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>Dorothy A. Ordover-Smith MD</u> | | | 22e. ADDRESS
<u>2601 E. Monmouth St. 21205</u> | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<u>Burial</u> | | | 23b. DATE
<u>12/29/86</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Oak Lawn Cem.</u> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<u>Baltimore Md.</u> | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
<u>B. Dabrowski & Son 2818 E. Baltimore St.</u> | | | | | | 25a. DATE REC'D. BY REGISTRAR
<u>DEC 29 1986</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Julia Davidson-Randall</u> | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

028237 DEC 1986

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6

3 4 8 1 7

REG. NO.

| | | | | | | |
|---|--|---|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Antonina Petrecca | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12-22-86 | | 2b. HOUR
12 30 P M | |
| 3. SEX
Female | | 4. RACE
C | | 5. DATE OF BIRTH
MONTH DAY YEAR
11 5 1895 | | 6. AGE (IN YEARS LAST BIRTHDAY)
91 YRS. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Italy | | 7b. CITIZEN OF WHAT COUNTRY?
Italy | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore MD. |
| 10. CITY OR TOWN OF DEATH
Dundalk | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Meridian Nursing Ct.-Heritage | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | |
| 13a. STATE
Md. | | | 13b. COUNTY
Balto. | | 13c. CITY OR TOWN
Balto. | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Anthony Ficca | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
215-92-5616 | | 17. INFORMANT
ADDRESS
Rose Olszewski 5114McFaulRoad 21206 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ACUTE CARDIO PULMONARY
DUE TO, OR AS A CONSEQUENCE OF
(b) - METASTATIC CA
DUE TO, OR AS A CONSEQUENCE OF
(c) CANCER OF COLOON
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 DAY
months
1 month | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from May 28, 1986 , to Dec 22, 1986 , that (I) (we) last saw the deceased alive on Dec 22, 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
B. C. Veneracion
DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
12/22/86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
B. C. VENERACION | | | | 22e. ADDRESS
3401 Dundalk Ave 21222 | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
12/24/86 | | 23c. NAME OF CEMETERY OR CREMATORY
Sacred Heart of Mary | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Dundalk Balto. Maryland |
| 24. FUNERAL DIRECTOR
NAME
Connelly Funeral Home
ADDRESS
300 Mace Ave. 21221 | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 24 1986 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall |

MEDICAL CERTIFICATION

BP

DHMM - 16 60M 7/84
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the official certifier and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove this certificate to the State Department of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body. Pages 1 and 2 should be filed within 72 hours after death. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

EX-100-100000

CHIEF IN CHARGE

DEC 24 1964

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | |
|--|--|--|--|---|------------------------------|---|
| 1. DECEASED NAME
FIRST MIDDLE LAST
Emma A. Pezzica | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 18 86 | | 2b. HOUR
3:30 p.m. | |
| 3. SEX
female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
3-19-1917 | | 6. AGE (IN YEARS LAST BIRTHDAY)
69
YRS. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Union Memorial Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md. | | 13b. COUNTY
Balto. | | 13c. CITY OR TOWN
Balto. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Natale Ferrari | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Maria Lodise | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
219-01-5820 | | 17. INFORMANT
ADDRESS
Md. 21014
Ernestine DuBois, 821 Flintlock Dr., Bel Air | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Congestive Heart Failure
DUE TO, OR AS A CONSEQUENCE OF:
(b) Chronic Heart Disease
DUE TO, OR AS A CONSEQUENCE OF:
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 yrs
60 yrs | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

 | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | |
| 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from May 19 86 to 12 18 86 , that (I) (we) lost
saw the deceased alive on 12 17 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
Francis T. Daly | | DEGREE
MD | | 22c. DATE SIGNED
12 18 86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Francis T. Daly | | 22e. ADDRESS
Union Memorial Hospital | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
12-22-86 | | 23c. NAME OF CEMETERY OR CREMATORY
Holy Redeemer | | |
| 23d. LOCATION
CITY OR TOWN
Balto., Md. | | 23e. COUNTY
Balto. | | | | |
| 24. FUNERAL DIRECTOR
NAME
Leonard J. Ruck, Inc., 5305 Harford Rd. | | 25a. DATE REC'D. BY REGISTRAR
DEC 19 1986 | | | | |
| 25b. REGISTRAR'S SIGNATURE
Julia D. ... | | | | | | |

BP

0575



[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page. Some words like "L.A.", "L.A. 100", and "L.A. 100" are visible.]

28624
8626 DEC 31 86

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 3 4 8 1 9

| | | | | | |
|---|--|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Jerome H. Pfeifer | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 25 86 | | 2b. HOUR
6 A M | |
| 3. SEX
Male | 4. RACE
Caucasian | 5. DATE OF BIRTH
MONTH DAY YEAR
03 27 22 | | 6. AGE (IN YEARS LAST BIRTHDAY)
64 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALT CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALT | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
LOCH RAVEN VA | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Bricklayer. | | 12b. KIND OF BUSINESS OR INDUSTRY
Union Local #1 |
| 13a. STATE
MD | | 13b. COUNTY
Baltimore | 13c. CITY OR TOWN
WHITE MARSH | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
21162
5919 LORELEY BEACH RD |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
George Pfeifer | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Barbara Diepold | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
213143704 | | 17. INFORMANT
ADDRESS
Margaret Pfeifer, Wife, same as above | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>COVIDIO PULMONARY ARREST</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>SEPSIS</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>minutes</u>
<u>Days</u> | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).
<u>SIP CVA, IDDM, SIP @ AKA</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>12/12</u> , 19 <u>86</u> , to <u>12/25</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>12/25</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22a. SIGNATURE
<u>RW Daly MD</u> | | DEGREE | | 22c. DATE SIGNED
12/25/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
RW DALY MD | | 22e. ADDRESS
LOCH RAVEN VETERANS HOSPITAL | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
12/29/86 | | 23c. NAME OF CEMETERY OR CREMATORY
St. Joseph's Cem. | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Maryland | | 23e. DATE REC'D. BY REGISTRAR 23f. REGISTRAR'S SIGNATURE
DEC 29 1986 | | | |
| 24. FUNERAL DIRECTOR
NAME
SCHIMUNEK FUNERAL HOME, Balto, Md. 21236 | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then page removal papers, Pages 1 and 2, should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked, item 18 shows any injury, other traumatic event, other traumatic event, the medical examiner must be notified at once.

1

STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | | |
|--|--|----------|-------------------|---|--|---|--|--|----------------|-------------------------|--|---|--|-----------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a. DATE KNOWN OF DEATH | | | MONTH DAY YEAR | | | 2b. HOUR | | | |
| ROBERT C. PFEIFFER | | | | | | 12 25 19 86 | | | | | | M | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | 2d. HOUR | |
| Male | | Cau. | | 2 22 21 | | 65 YRS. | | | | | | 12 25 19 86 | | 3:42 P.M. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Maryland | | | | U.S.A. | | | | | | | | Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Baltimore | | | | 1134 S. Hanover St. | | | | Painter | | | | Self-Employed | | | |
| 13a. STATE | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | |
| Md. | | | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 1134 South Hanover Street 21202 | | | | | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | |
| Aloysius J. Pfeiffer | | | | Mary Robl | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | ADDRESS | | | | | |
| Yes | | WW 11 | | 215-14-8953A | | Aloysius J. Pfeiffer | | | | 6253 Hanover Road 21076 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. | | | | | | | | | | | | | | | |
| (b) | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? | | | |
| | | | | | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| | | | | P.M. 19 | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION | | | | | | | |
| | | | | | | | | STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | TITLE (SPECIFY) | | | | | | | | DATE SIGNED | | | |
| | | | | M.D. Deputy Chief | | | | | | | | 12-26-86 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS | | | | | | | | | | | |
| Ann M. Dixon, M.D. | | | | 111 PennSt., Balto., MD 21201 | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION | | | | | |
| Cremation | | 12-27-86 | | Security Process | | | | Baltimore | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| NAME ADDRESS | | | | DEC 29 1986 | | | | | | | | | | | |
| Cremation Society of Md. Inc. | | | | | | | | | | | | | | | |

8884 113

UNIT 1000-113

UNIT 1000-113

029121 JAN 5 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|---|---|-----------------------------|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
ELIZABETH PHELPS | | | 2a. DATE OF DEATH
MONTH DAY YEAR
DECEMBER 30, 1986 | | 2b. HOUR
12:40P M | | |
| 3. SEX
Female | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
7 9 1912 | | 6. AGE (IN YEARS LAST BIRTHDAY)
74
YRS. MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN)
Rocky Mt., N.C. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE JOHNS HOPKINS HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Presser | | 12b. KIND OF BUSINESS OR INDUSTRY
none | |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE Md. 13b. COUNTY Baltimore 13c. CITY OR TOWN Baltimore 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS / ZIP CODE 1638 N. Broadway 21213 | | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
unknown | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Charlotte Battle | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
212-24-9205 A | | 17. INFORMANT ADDRESS
Deborah L. Fogg 6307 Laurelton Ave. | | | |

| | | |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) RUPTURED ABDOMINAL AORTIC ANEURYSM
DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROSIS
DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIOSCLEROSIS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2-24°
YEARS |
|--|--|---|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION
12/30/86 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
RUPTURED ANEURYSM | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) received the deceased from 12/30 1:45A 1986 , to 12/30 1986 , that (I) (we) last saw the deceased alive on 12/30 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Benjamin D. Knox | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
12/30/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
BENJAMIN D. KNOX | | | | 22e. ADDRESS
600 N. WOLFE ST. BALTO., MD 21205 | | | |

| | | | | | | | |
|--|--|----------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
1-3-86 | | 23c. NAME OF CEMETERY OR CREMATORY
Baltimore Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Md. | |
| 24. FUNERAL DIRECTOR
NAME
Wm. J. Spicer F.H. 1639 N. Broadway | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 2 1987 | | 25b. REGISTRAR'S SIGNATURE
Julia Dindon-Rudman | |

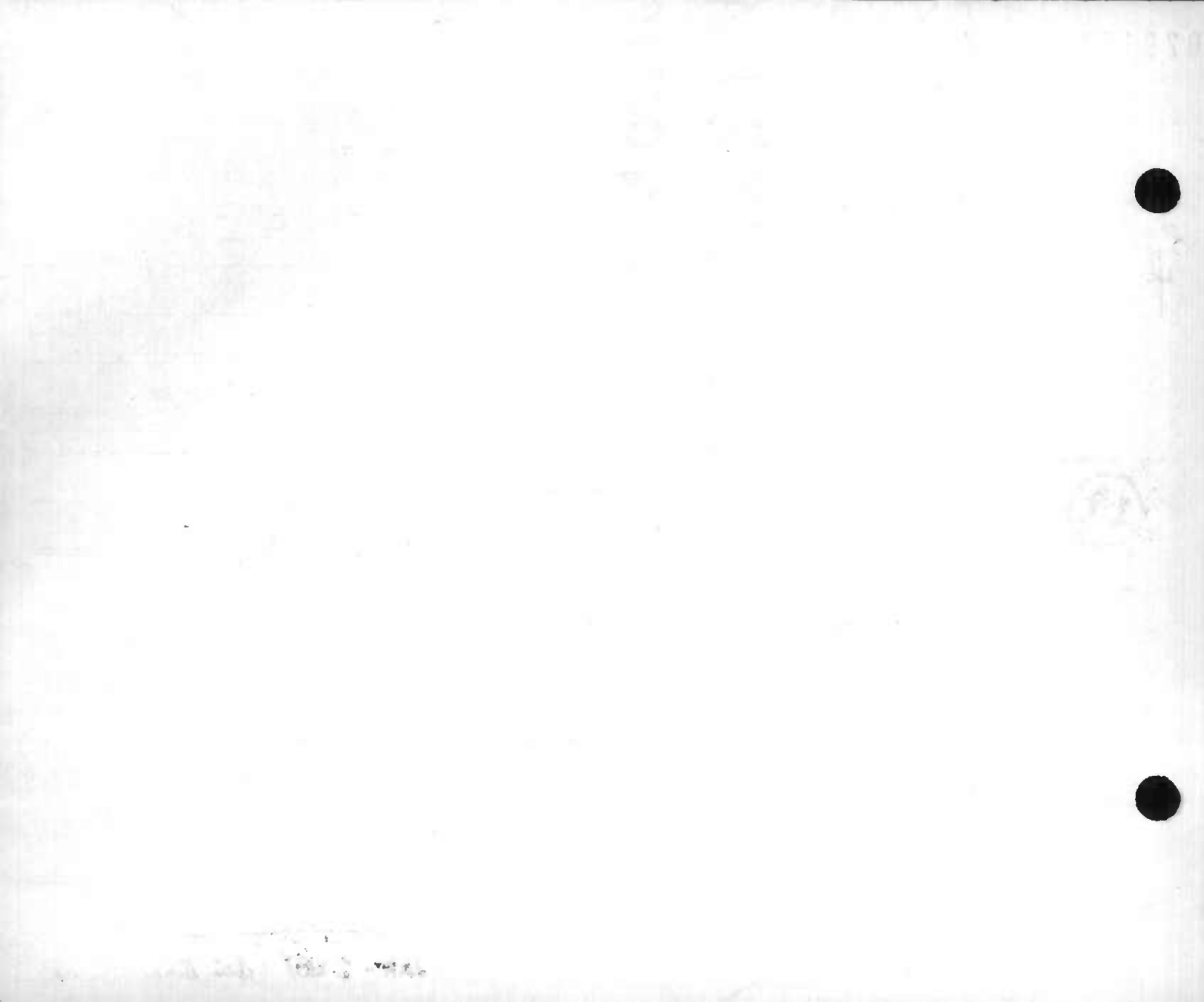
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

RELEASED NON NED DR IM ZANE PER MR. LAWYER

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then place in the container with the deceased. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|--|--|---|--|
| 1- FOR
STATE
REGISTRAR | | | | 2a DATE OF DEATH MONTH DAY YEAR | | | | 2b HOUR | | | |
| 1- DECEASED NAME
(TYPE OR PRINT)
Joseph J. Phillips | | | | December 9, 1986 | | | | — M | | | |
| 3 SEX
Male | | 4 RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Jan. 9, 1918 | | | | 6 AGE (IN YEARS LAST BIRTHDAY)
68 | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
2212 Louise Avenue 21214 | | | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Expeditor | | | | 12b KIND OF BUSINESS OR INDUSTRY
Aerospace | |
| 13a STATE
Maryland | | | | 13b COUNTY | | 13c CITY OR TOWN
Baltimore | | 13d INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
John Joseph Phillips | | | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Barbara Goszka | | | | 13e STREET ADDRESS / ZIP CODE
2212 Louise Avenue 21214 | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | | | 16b SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WW II | | 17 INFORMANT
ADDRESS
Helen E. Phillips same as 13e | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Myocardial infarction
DUE TO, OR AS A CONSEQUENCE OF
(b) Hypertensive heart disease
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
— | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | | | |
| 19a DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from for 19 82 , to 12/9 19 86 , that I (we) last saw the deceased alive on 12/9 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b SIGNATURE
Stuart B. Bell MD | | | | DEGREE
MD | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12/10/86 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)
Stuart B. Bell MD | | | | 22e ADDRESS
3501 St. Paul Street Baltimore, Maryland | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL
(SPECIFY)
Entombment | | | | 23b. DATE
12/12/1986 | | 23c. NAME OF CEMETERY OR CREMATORY
Dulaney Valley | | 23d LOCATION
CITY OR TOWN COUNTY STATE
Timonium. Maryland | | | |
| 24 FUNERAL DIRECTOR
Leonard J. Ruck Inc. Baltimore, Maryland | | | | | | 25a DATE REC'D. BY REGISTRAR
DEC 11 1986 | | 25b REGISTRAR'S SIGNATURE
John Frederick Ruck | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then place the return of the burial-transit permit in the envelope and return it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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December 9, 1982

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12.11.1982

027170 DEC

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|---|--|--|--|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
DOROTHY A PIERAZIO | | | 2a. DATE OF DEATH
MONTH DAY YEAR
DECEMBER 8, 1986 | | | 2b. HOUR
4:30A M | | | |
| 3 SEX
FEMALE | | 4 RACE
CAUCASIAN | | 5. DATE OF BIRTH
MONTH DAY YEAR
5 28 '23 | | 6 AGE (IN YEARS LAST BIRTHDAY)
63 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
IF UNDER 24 HRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New York | | 7b. CITIZEN OF WHAT COUNTRY?
U S A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | |
| 10 CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE JOHNS HOPKINS HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
Homemaker | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MARYLAND | | 13b. CITY OR TOWN
A A | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13c. STREET ADDRESS / ZIP CODE
2003 Norman Road 21061 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
James A Evans | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ethel Ross | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
073 18 4087 | | 17 INFORMATION
Glen Burnie, Maryland 21061
Dorothy A Pierazio 2003 Norman Road | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardio pulmonary arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Stage III Cerebral Parenchyma</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/4/86</u> , 19 <u>86</u> , to <u>12/8</u> , 19 <u>86</u> , that (I) (we) lost
saw the deceased alive on <u>12/8</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Mark F. Peterson MD | | | | | | DEGREE | | 22c. DATE SIGNED
12/8/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MARK F. PETERSON MD | | | | | | 22e. ADDRESS
Johns Hopkins Hospital Baltimore Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | | 23b. DATE
12/12/86 | | 23c. NAME OF CEMETERY OR CREMATORY
Saint Mary's | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Yonkers Westchester N Y | | |
| 24 FUNERAL DIRECTOR
NAME
Raymond C Fink Glen Burnie, Md 21061 | | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 12 1986 | | 25b. REGISTRAR'S SIGNATURE
Julian [Signature] | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the funeral director, page 3 with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

CAUTION

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027991

DEC

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | |
|---|--|--|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST <u>AKA ELEANOR B.</u> MIDDLE <u>PINKNEY</u> LAST <u>PINKNEY</u> | | 2a. DATE OF DEATH MONTH <u>12</u> DAY <u>14</u> YEAR <u>86</u> | | 2b. HOUR <u>12⁴⁵ AM</u> |
| 3. SEX <u>F</u> | 4. RACE <u>B</u> | 5. DATE OF BIRTH MONTH <u>2</u> DAY <u>19</u> YEAR <u>13</u> | 6. AGE (IN YEARS LAST BIRTHDAY) <u>73</u> YRS. | IF UNDER 1 YEAR MONTHS <u></u> DAYS <u></u> IF UNDER 24 HRS. HOURS <u></u> MIN. <u></u> |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>VIRGINIA</u> | 7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>BALTIMORE</u> MD. | |
| 10. CITY OR TOWN OF DEATH <u>BALTIMORE</u> | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Liberty Med Center</u> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Homemaker</u> | 12b. KIND OF BUSINESS OR INDUSTRY <u></u> |
| 13a. STATE <u>MARYLAND</u> | 13b. COUNTY <u></u> | 13c. CITY OR TOWN <u>BALTIMORE</u> | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE <u>401 E. 25th St Apt 42 J1218</u> |
| 14. FATHER'S NAME FIRST <u>ALEXANDER</u> MIDDLE <u>WOOD</u> LAST <u></u> | | 15. MOTHER'S MAIDEN NAME FIRST <u>NINA</u> MIDDLE <u>GARNER</u> LAST <u></u> | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u> | | 16b. SOCIAL SECURITY NO. <u>220 14 5374</u> | | 17. INFORMANT ADDRESS <u>Mrs Clara Dyson 4933 Edgemere Ave J1215</u> |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>ELECTROMECHANICAL DISSOCIATION</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>S/P MI MYOCARDIAL INFARCTION</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 WKS</u> | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u></u> | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u> | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/14</u> , 19 <u>86</u> , to <u>12/14</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>12/14</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | |
| 22b. SIGNATURE <u>C. E. Hays</u> | | DEGREE | | 22c. DATE SIGNED <u>12/14/86</u> |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>HARMATZ, ALON</u> | | 22e. ADDRESS <u>LIBERTY MED CENTER, BALT, MD</u> | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>B</u> | 23b. DATE <u>12/16/86</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u> | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| 24. FUNERAL DIRECTOR NAME <u>Joseph C. Russ</u> ADDRESS <u>2222 W. North Ave</u> | | 25a. DATE REC'D. BY REGISTRAR <u>DEC 19 1986</u> | 25b. REGISTRAR'S SIGNATURE <u>Julia Decker-Randall</u> | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, a medical examiner must be notified and a post-mortem examination must be made.

05780

20% COLLOIDAL



05780

28714 DEC 31 1986

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 3 4 8 2 5

REG. NO.

| | | | | | | | | | | | |
|--|--|---|--|---|--------------------|--|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
ELSIE PLAUT | | | 2a. DATE OF DEATH
MONTH DAY YEAR
DECEMBER 23, 1986 | | 2b. HOUR
3 P.M. | | | | | | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
NOV. 7, 1893 | | 6. AGE (IN YEARS LAST BIRTHDAY)
93 YRS | | 7. IF UNDER 1 YEAR
MONTHS DAYS | | 8. IF UNDER 24 HRS
HOURS MIN. | |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 9b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
2500 W. BELVEDERE AVE., APT. 311 | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
SECRETARY | | 12b. KIND OF BUSINESS OR INDUSTRY
RETAIL | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
STATE
MARYLAND | | | | | | 13b. COUNTY | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
MEYER PLAUT | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
HENRIETTA SCHNEEBERGER | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
215-01-5252 | | 17. INFORMANT
PHILIP W. ADERMAN
3917 SYBIL RD. RANDALLSTOWN, MD 21133 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiac arrhythmia</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Acute MI suspected</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Chronic C-V. disease</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>acute</u>
<u>acute</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>Dementia, Diabetes</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (1) (the hospital) attended the deceased from <u>1-25</u> 19 <u>85</u> to <u>12-23</u> 19 <u>86</u> , that (1) (we) last saw the deceased alive on <u>12-16-86</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>H. Gerald Oster MD</u> | | | | DEGREE
<u>MD</u> | | | | 22c. DATE SIGNED
DEC. 23, 1986 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JOSEPH DECKELBAUM | | | | 22e. ADDRESS
3635 OLD COURT ROAD | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(CHECK ONE)
BURIAL | | | | 23b. DATE
DEC. 24, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY
BALTIMORE HEBREW | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE BALTIMORE MARYLAND | | | |
| 24. FUNERAL DIRECTOR
NAME
SOL LEVINSON & BROS., INC.
6010 REISTERSTOWN RD. BALTO., MD 21215 | | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 30 1986 | | 25b. REGISTRAR'S SIGNATURE
<u>Julia Davidson-Randall</u> | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

BP

[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "C. 10" and "C. 11" are visible.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The (a) above is the death certificate to be executed within 24 hours after death. Page 4 may be retained by the hospital, attending physician, or funeral director. The (b) above is the death certificate to be retained by the hospital, attending physician, or funeral director. After the attending physician has signed the (b) above, it should be detached for use as the burial or cremation permit. This permit is not valid unless it is signed by the attending physician with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal. IMPORTANT: If item 21 is marked on item 18, indicates any injury, or other traumatic event, the medical examiner must be notified and a medical certificate filed.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|--|--|--|---|--|-----------------------------------|--|-----|--|----------|--|---|
| 1. DECEASED NAME
(OR PRINT) | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | MONTH | DAY | YEAR | 2b. HOUR | P | M |
| WILLIAM BENNETT PHILLIPS | | | | | DECEMBER 23, 1986 | | | | 6:00 | | |
| 1. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | |
| Male | White | May 15, 1911 | | 75 | | YRS. | | MONTHS | | DAYS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | BALTIMORE CITY MD. | | | |
| Maryland | U. S. A. | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | |
| BALTIMORE | THE JOHNS HOPKINS HOSPITAL | | Accountant | | Perdue | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS / ZIP CODE | | | |
| Maryland | | Wicomico | | Salisbury | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 1905 Kipling Drive 21801 | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| John Edwin Phillips | | | | Gertrude Bennett | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | |
| Yes | | | | WW II | | 214-10-9586 | | Eunice Ellis Phillips (same as above) | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u> | | | | | | | | | | 5 minutes | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | colon cancer | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | years | |
| (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | |
| | | P.M. 19 | | | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | | | | | | | |
| WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | STREET | | CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that, (1) this hospital attended the deceased from <u>Dec 23</u> , 19 <u>86</u> , to <u>Dec 23</u> , 19 <u>86</u> , that (2) <u>we</u> lost saw the deceased alive on <u>Dec 23</u> , 19 <u>86</u> , and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above, (3) <u>we</u> (did) did not view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | | | 22c. DATE SIGNED | | | | | |
| <u>Robert Strumpf</u> | | MD | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | Dec 23, 1986 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | | | |
| Robert Strumpf | | 600 N. Wolfe Street Baltimore, MD 21205 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | | | |
| Burial | | Dec. 27, 1986 | | Firemen's Cemetery | | Sharptown, Wicomico Maryland | | | | | |
| 24. FUNERAL DIRECTOR | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| Marvel-Short Funeral Home Delmar, Delaware | | | | DEC 30 1986 | | <u>Julia Davidson-Randall</u> | | | | | |

1050

20% CONTAINMENT



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 34827
REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | |
|---|---|--|---|---|
| DECEASED NAME
FIRST MIDDLE LAST
JEREMIAH PINDELL | | 7a. DATE OF DEATH
MONTH DAY YEAR
12-30-86 | | 7b. HOUR
7:31 AM |
| 3 SEX
MALE | 4 RACE
BLACK | 5. DATE OF BIRTH
MONTH DAY YEAR
12 11 03 | 6 AGE (IN YEARS LAST BIRTHDAY)
83 | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
IF UNDER 24 HRS. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
USA | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH
BALTO CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTO | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
MARYLAND GENL. HOSP | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MD | 13b. COUNTY
AA | 13c. CITY OR TOWN
ANNAPOLIS | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
1922 FORREST DR
ANNAPOLIS, MD 21401 |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
PHILLIP PINDELL | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
FRANCIS E PINDELL | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
UNKNOWN | 16b. SOCIAL SECURITY NO.
220/07/1279 | 17. INFORMANT
GORDON | ADDRESS
1922 FORREST
B PINDELL DRIVE | |

| | | |
|--|--|--|
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ACUTE MASSIVE MI
DUE TO, OR AS A CONSEQUENCE OF
(b) HA SE US
DUE TO, OR AS A CONSEQUENCE OF
(c) CEREBRAL HEMORRHAGE | | APPROXIMATE PERIOD BETWEEN ONSET AND DEATH
1 hr.
years
years |
|--|--|--|

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a
ADM

| | | | |
|---|--|--|--|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | |
| 21d. INJURY OCCURRED
AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (the hospital) attended the deceased from 12-26 19 86 to 12-30 19 86 that (I) (the) last saw the deceased alive on 12-29 19 86 and that in (my) (my) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (not) view the body after death. | | | |

| | | |
|---|---|-------------------------------------|
| 22b. SIGNATURE
Richard Tyson, M.D. | DEGREE
M.D. | 22c. DATE SIGNED
12-30-86 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
RICHARD TYSON, M.D. | 22e. ADDRESS
936 W. NORTH AV.
BALTIMORE, MD 21217 | |

| | | | |
|---|----------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | 23b. DATE
1/6/87 | 23c. NAME OF CEMETERY OR CREMATORY
PINE LAWN MEM PK. | 23d. LOCATION
CITY OR TOWN COUNTY STATE
ANNAP. A.A. MD. |
| 24. FUNERAL DIRECTOR
REESE & SONS | | ADDRESS
821 WEST ST | 25a. DATE RECD. BY REGISTRAR
DEC 31 1986 |
| | | 25b. REGISTRAR'S SIGNATURE
Julia D. ... | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

27277 DEC 16 1986

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed and filed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy, page 4, and return it to the funeral director with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|--|---|--|---|--|--|--|
| 1- FOR STATE REGISTRAR | | | | | REG. NO. | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
DAMON M. PLEASANT | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12/11/86 | | | 2b. HOUR
11:15 P.M. | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
10 25 22 | | 6. AGE (IN YEARS LAST BIRTHDAY)
64 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
KY. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
University of Maryland | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Warehouseman | | 12b. KIND OF BUSINESS OR INDUSTRY
Koppers Co. | |
| 13a. STATE
Maryland | | | | | 13b. CITY OR TOWN
Baltimore | | 13c. STREET ADDRESS / ZIP CODE
4421 Alan Drive Apt. B 21229 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Curt M. Pleasant | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Betty Cox | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
YES | | | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WW II | | 17. INFORMANT ADDRESS
Viola Pleasant 4421 Alan Dr. Apt. B 21229 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Stage III Adeno Carcinoma of lung
DUE TO, OR AS A CONSEQUENCE OF
(b) Venous Thromboembolic disease
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
9/86
11/86 | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | |
| 19a. DATE OF OPERATION
None | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/1/86, 19, to 12/11/86, 19, that (I) (we) lost saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Rodger A. Blake | | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED
12/11/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Rodger A. Blake | | | | | 22e. ADDRESS
University Hospital 22 S. Green St. Baltimore, MD | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
12/15/86 | | 23c. NAME OF CEMETERY OR CREMATORY
Crownsville Vet. Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Crownsville A.A. Maryland | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Hubbard Funeral Home, Inc. 4107 Wilkens Ave. 21229 | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 15 1986 | | 25b. REGISTRAR'S SIGNATURE
Julia Swiders-Randall | | |

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[Handwritten mark, possibly "H"]

[Handwritten mark, possibly "C"]

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|---|--|--|--|--|--|---|--|---|--|-----------------------------------|--|---|--|--|--|--------------------------------|--|--|--|-------------------------------|--|--|--|----------------------------|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH | | MONTH | | DAY | | YEAR | | 2b. HOUR | | | | | | | | | | | | | | | |
| YEUBEART GORDON | | | | | | POE | | 12 | | 28 | | 86 | | 10 | | 44 AM | | | | | | | | | | | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | | 7. IF UNDER 1 YEAR | | | | 7. IF UNDER 24 HRS | | | | | | | | | | | | | | | |
| MALE | | BLACK | | MONTH 6 DAY 18 YEAR 56 | | | | 30 | | | | MONTHS DAYS HOURS MIN. | | | | | | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | | | | | | | | | | | |
| MD, USA | | USA A | | | | | | | | BALTIMORE CITY | | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | |
| BALTIMORE | | Univ. Maryland Hospital | | | | | | | | SALESPERSON | | | | LIQUOR | | | | | | | | | | | | | | | | | |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | | | | | | 13d. INSIDE CITY LIMITS? | | | | 13e. STREET ADDRESS / ZIP CODE | | | | | | | | | | | |
| 13a. STATE 13b. COUNTY 13c. CITY OR TOWN | | | | | | | | | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 2726 HARLEM AVE 21216 | | | | | | | | | | | |
| 14. FATHER'S NAME | | | | | | | | | | | | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | |
| YEUBEART LEE POE | | | | | | | | | | | | | | | | EMMA ROSETTA JOHNSON | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT ADDRESS | | | | | | | | | | | | | | | | | | | | | | | |
| YES | | | | 1970 S | | | | YEUBEART L. POE 4109 KATHLAND AVE | | | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Brain death - herniation | | | | | | | | | | | | | | | | 8 hours | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Brain edema | | | | | | | | | | | | | | | | 2 days | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) likely encephalitis/encephalopathy | | | | | | | | | | | | | | | | 7 days | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Intravenous drug abuse | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | | | | | |
| NONE | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | P.M. 19 | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12-22, 1986, to 12-28, 1986, that (I) (we) lost saw the deceased alive on 12-28-86, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) did (did not) view the body after death. | | | | | | | | | | | | | | | | 22c. DATE SIGNED | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | | | | | | | | DEGREE | | | | 22c. DATE SIGNED | | | | | | | | | | | |
| John A. Ulatowski | | | | | | | | | | | | | | | | MD/PHD | | | | 12-28-86 | | | | | | | | | | | |
| 23a. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | | | | | | | | | | | 23b. ADDRESS | | | | | | | | 23c. DATE REC'D. BY REGISTRAR | | | | 23d. REGISTRAR'S SIGNATURE | | | |
| John A. Ulatowski | | | | | | | | | | | | | | | | DEPT. Neurology Univ. Md. Hospital 22 S. Greenest. Balt. Md. 21201 | | | | | | | | DEC 31 1986 | | | | Julia Davidson-Randall | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | | | | | | | |
| Burial | | | | 12/31/86 | | | | Garrison Forest | | | | Owings Mills Md. | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS | | | | | | | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | |
| W.C. March F.H. 4300 Wabash Ave. | | | | | | | | | | | | | | | | DEC 31 1986 | | | | Julia Davidson-Randall | | | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN; The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers from the form and it should be filed with the 2 hours after death certificate in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

BP_____

[The text in this document is extremely faint and illegible. It appears to be a multi-page report or document with several sections, possibly containing tables and headings. The visible fragments of text are too blurry to transcribe accurately.]

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be certified within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | |
| 3. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST | | | | 2b. HOUR | | | |
| Helen E. POLCAK | | | | 12 20 86 145 A M | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| Female | | White | | Nov. 23 15 | | 71 YRS. | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| Maryland | | USA | | | | Baltimore City MD | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Baltimore | | St. Agnes Hospital | | Assembly Line | | Glen L. Martin | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY | | | | 13b. CITY OR TOWN | | | |
| Maryland --- | | | | Baltimore | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | |
| Marian Jagodonski | | | | Sophie Bortosiak | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | | | 16b. SOCIAL SECURITY NO. | | | |
| No --- | | | | 218-01-8639 | | | |
| 17. INFORMANT ADDRESS | | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | |
| Jerry Polcak, 1612 Spence Street | | | | PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest | | | |
| | | | | DUE TO, OR AS A CONSEQUENCE OF (b) Liver Cirrhosis | | | |
| | | | | DUE TO, OR AS A CONSEQUENCE OF (c) | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| | | P.M. 19 | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| | | | | | | | |
| 22a. I certify that (1) this hospital attended the deceased from 11/25 19 86 to 12/20 19 86 , that (2) we lost saw the deceased alive on 12/20 19 86 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (2) we (did/did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE DEGREE | | | | 22c. DATE SIGNED | | | |
| Bulent Atac | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | |
| Bulent Atac | | | | St. Agnes Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| Burial | | 12/23/86 | | Loudon Park Cemetery | | Baltimore Maryland | |
| 24. FUNERAL DIRECTOR NAME ADDRESS | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Hubbard Funeral Home, Inc., 4107 Wilkens Ave. | | | | 21229 DEC 22 1986 | | Julia Seiden-Lindner | |

027677 DEC 19 86

Item # 7a Film G 622, 12/29/86 ra

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|---|--|--|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT) John m. Polychrones | | | 2a. DATE OF DEATH
MONTH DAY YEAR
Dec. 12 10 86 | | 2b. HOUR
7:10 A.M. |
| 3. SEX
male | 4. RACE
white | 5. DATE OF BIRTH
DAY MONTH YEAR
10 02 33 | 6. AGE (IN YEARS LAST BIRTHDAY)
53 YRS | IF UNDER 1 YEAR
MONTHS DAYS
— — | IF UNDER 24 HRS
HOURS MIN.
— — |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Washington, DC. | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore, MD. | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
University of Maryland Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Program Analyst | 12b. KIND OF BUSINESS OR INDUSTRY
U.S. Govt. | |
| 13a. STATE
Virginia | | 13b. COUNTY
Alexandria | 13c. CITY OR TOWN
Alexandria | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
1111 Dartmouth Rd. 22314 |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Michail John Polychrones | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Drossos | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
Korea 226-38-8491 | 17. INFORMANT
ADDRESS
Lillian M. Shaw 1111 Dartmouth R. VA. Alexandria | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute respiratory failure
DUE TO, OR AS A CONSEQUENCE OF
(b) Metabolic acidosis
DUE TO, OR AS A CONSEQUENCE OF
(c) Acute renal failure | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: () | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/04/1986 to 12/10/1986 that (I) (we) lost
saw the deceased alive on 12/10/1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Jeffrey Joe, MD | | DEGREE
MD | | 22c. DATE SIGNED
12/10/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Jeffrey Joe, MD | | 22e. ADDRESS
22 S. Greene St., Baltimore, MD 21201 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Dec. 15, 86 | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Comfort Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Alexandria Fairfax VA. |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Everly-Wheatley Funeral Home
1500 W. Braddock Rd. Alexandria, Va. | | | 25a. DATE REC'D. BY REGISTRAR
DEC 15 1986 | | |
| | | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Rodgers | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. These places are marked on the papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other suspicious event, the medical examiner must be notified at once.

027286 DEC

6 06
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|--|--|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
HERBERT N POOLE JR. | | | 2a. DATE OF DEATH
MONTH DAY YEAR
DECEMBER 10, 1986 | | 2b. HOUR
09:04^P |
| 3. SEX
M | 4. RACE
B | 5. DATE OF BIRTH
MONTH DAY YEAR
10 2 78 | 6. AGE (IN YEARS LAST BIRTHDAY)
8 YRS | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(GIVE FULL FACILITY AND STREET ADDRESS)
JOHNS HOPKINS HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
N/A | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MD | | | 13b. COUNTY
BALTO. | 13c. CITY OR TOWN
BALTO. | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
HERBERT POOLE JR. | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ANNA STERLING | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | 16b. SOCIAL SECURITY NO.
213 925677 | | 17. INFORMANT
ADDRESS
ANNA DOCKINS 226 N. COLLINGTON AVE. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Varicella pneumonia
DUE TO, OR AS A CONSEQUENCE OF
(b) Aspiration pneumonia
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)
Hydroencephaly | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 days
5 days |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)
21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>
21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/09 , 19 86 , to 12/10 , 19 86 , that (I) (we) lost saw the deceased alive on 12/10 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Linda Solow
DEGREE
MD | | | | 22c. DATE SIGNED
12/10/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Linda Solow | | | | 22e. ADDRESS
Johns Hopkins Hospital
600 North Wolfe Street. | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
12-15-86 | 23c. NAME OF CEMETERY OR CREMATORY
Baltimore Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE MD |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
MARCH FUNERAL HOME 1101 E. NORTH AVE. | | | 25a. DATE REC'D. BY REGISTRAR
DEC 15 1986 | | 25b. REGISTRAR'S SIGNATURE
Linda Davidson-Randall |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The **10** requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial transit permit. Then please include carbon paper copy with the State Dept. of Health and Mental Hygiene prior to burial. (See page 2 of Manual.)

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



28768 DEC 31 86

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|---|---|--|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MARY MIDDLE GWENDOLYN LAST POOLE | | | 2a. DATE OF DEATH
MONTH DAY YEAR
DECEMBER 23, 1986 | | 2b. HOUR
8:00P M |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
July 25, 1945 | | 6. AGE (IN YEARS LAST BIRTHDAY)
41 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
South Carolina | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE JOHNS HOPKINS HOSPITAL | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Laborer | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE South Carolina 13b. COUNTY Sumter 13c. CITY OR TOWN Sumter | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
2115 Poole Rd. 29154 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Ronny Poole | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ethel Wilder | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
249-76-5416 | | 17. INFORMANT
ADDRESS
Eugene Poole, 2005 Poole Rd. 29154 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest.</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Trichosporium beglii sepsis</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>leukopenia</u> | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
5 min.
25 days
55 days |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a
<u>Bone marrow transplant for Chronic myelogenous leukemia</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10/19</u> , 19 <u>86</u> , to <u>12/23</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>12/23</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>MB Fasano, MD</u> | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
<u>12/23/86</u> |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>FASANO</u> | | | 22e. ADDRESS
<u>Johns Hopkins Hospital.</u> | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Dec. 27, 1986 | 23c. NAME OF CEMETERY OR CREMATORY
Calvary Nazarene | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Sumter Sumter S.C. |
| 24. FUNERAL DIRECTOR
NAME
ROBERT C. ALTENBURG FUNERAL HOME, INC.
6009 Harford Rd., Balto., Md. 21214 | | | 25a. DATE REC'D. BY REGISTRAR
DEC 29 1986 | | 25b. REGISTRAR'S SIGNATURE
<u>Julia Davidson-Randall</u> |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the funeral director, page 3 should be detached for use as the burial permit. Then please remove card to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.
IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified immediately.

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DEC 17 1986

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|---|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST MIDDLE LAST | | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR | |
| ROBERT POOLE | | | | 12 14 86 | | M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR MONTHS DAYS | |
| MALE | BLACK | 7 17 1905 | | 81 YRS. | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| N. CAROLINA | U. S. A. | | | BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| BALTIMORE | 908 WALNUT AVENUE | | STEELWORKER | | BETHLEHEM STEEL | | |
| 13a. STATE | | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| MARYLAND | | | BALTIMORE | 13e. STREET ADDRESS / ZIP CODE BALTIMORE, MD. 908 N. WALNUT AVENUE, 21228 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | |
| JEFF POOLE | | ROXIE BOWMAN | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| NO. | | 213-07-0754 | | MRS. BALTIMORE, MARYLAND MARY V. POOLE 908 N. WALNUT AVENUE, 21228 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Renal Failure</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>1 month</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Pericardial disease</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Constrictive Heart Failure</u> | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>12-8</u> 19 <u>81</u> , to <u>12-14</u> 19 <u>86</u> , that (I) (we) lost <u>12-14</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death. | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | |
| Joseph F. B. L. O. J. W. D. | | 3809 Grammont Ave Balto 21214 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | |
| BURIAL | | 12/19/1986 | WOODLAWN CEMETERY | | BALTIMORE, MARYLAND | | |
| 24. FUNERAL DIRECTOR TO NAME ADDRESS | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| MUTTER & SONS FUNERAL HOME, INC. 2501 Gwynns Falls Pkwy. Baltimore, Md. 21216 | | | | DEC 17 1986 | | Julia Swinton-Randall | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and properly filed in the funeral director's office, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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| NAME | SEX | RACE | DATE | AGE | RESIDENCE | RELATIONSHIP |
|-------------------|------|-------|----------|-----|--------------------------------|--------------|
| N. CAROLINE | MALE | BLACK | 11-1-02 | 31 | BALTIMORE CITY | STEELWORKER |
| BALTIMORE | | | | | BALTIMORE, MD. | |
| MARYLAND | | | | | 908 N. BALTIMORE AVENUE, 21228 | |
| JERRY | POOR | | | | BALTIMORE, MARYLAND | |
| MRS. MARY V. POOL | | | 11-07-02 | 31 | 908 N. BALTIMORE AVENUE, 21228 | |
| ROXIE | | | | | BALTIMORE, MARYLAND | |
| ROXAN | | | | | BALTIMORE, MARYLAND | |

BALTIMORE, MARYLAND
BUTLER & SONS FURNACE WORKS, INC.
1501 Gwynne Falls Ferry, Baltimore, Md. 21210

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 3 4 8 3 5

FOR
1- STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | | |
|--|--|--|---|---|-----------------------|---|--|--|--|---|--|
| 1. DECEASED NAME
(1) FIRST (2) MIDDLE (3) LAST
WILLIAM L. POOLE | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 10 86 | | 2b. HOUR
6:30 P.M. | | | | | | |
| 3. SEX
MALE | | 4. RACE
BLACK | | 5. DATE OF BIRTH
MONTH DAY YEAR
5 11 05 | | 6. AGE (IN YEARS LAST BIRTHDAY)
81 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | 8. IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
SC. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Deaton Medical Center | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Crane Operator | | | 12b. KIND OF BUSINESS OR INDUSTRY
Factory | | |
| 13a. STATE
Md. | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
1312 Edison Highway 21213 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Orange | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Annie Craig | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | 16b. SOCIAL SECURITY NO.
217-16-7089 | | 17. INFORMANT ADDRESS
Norma Griffin 3810 The Alameda | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST
DUE TO, OR AS A CONSEQUENCE OF
(b) METASTATIC PROSTATIC CARCINOMA
DUE TO, OR AS A CONSEQUENCE OF
(c)
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| MEDICAL CERTIFICATION | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from AUG 13 19 85 to DEC 10 19 86, that (I) (we) last saw the deceased alive on DEC 10 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
G.A. Hopper, M.D. | | | | | | | | DEGREE | | 22c. DATE SIGNED
12/10/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
GAYLE A. HOPPER, M.D. | | | | | | | | 22e. ADDRESS
DEATON MED CENTER, BALT. MD 21207 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | | 23b. DATE
12-16-86 | | 23c. NAME OF CEMETERY OR CREMATORY
Baltimore Cmty. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Md. | | 23e. DATE REC'D. BY REGISTRAR | |
| 24. FUNERAL DIRECTOR
NAME
Randolph J. Collick 2431 E. Oliver St. | | | | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 16 1986 | | 25b. REGISTRAR'S SIGNATURE | |

027297 DEC

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or other qualified person, it should be detached for use as the burial-transit permit. Then please remove and complete. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition.

IMPORTANT: If item 21 is marked as item 1B, show any injury, or other traumatic event. If marked as item 1B, show any injury, or other traumatic event.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|---|--|--|--|---|--|--|
| REG. NO. | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | | 2a. DATE OF DEATH | | | MONTH DAY YEAR | | 2b. HOUR | |
| CORY WILLIAM POTH | | | DECEMBER 12, 1986 | | 5:08 A.M. | | | | |
| 1. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR | |
| MALE | | WHITE | | JULY 23, 1986 | | - YRS 4 19 DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| PENNSYLVANIA | | U.S.A. | | | | BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| BALTIMORE | | JOHNS HOPKINS HOSPITAL | | | - | | - | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | 13b. STATE | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | |
| Maryland | | | Baltimore | | 21234 | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | 13e. STREET ADDRESS / ZIP CODE | | | |
| Matthew R. Poth | | | Christine Ann Huff | | | 1106 Halstead Rd. 21234 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | |
| No | | | None | | Matthew R. Poth 1106 Halstead Rd 21234 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Respiratory Failure</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Prematurity</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>1hr 30 min</u>
<u>3:30 am - 5:00 am</u>
<u>(12/12/86)</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | | | | | |
| 9a. DATE OF OPERATION | | | 9b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3:30 am 12/12, 19 86</u> , to <u>5 am 12/12</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>Dec. 12</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>Howard Markel</u> | | | DEGREE
<u>AB, M.D.</u> | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
<u>12/12/86</u> | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>Howard Markel, MD</u> | | | 22e. ADDRESS
<u>Johns Hopkins Hosp. 600 N. Wolfe Balto. MD 21205</u> | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | |
| Burial | | | 12/13/86 | | Evergreen Memorial | | Carroll Co., Maryland | | |
| 24. FUNERAL DIRECTOR
<u>William E. Johnson</u> | | | ADDRESS
<u>8521 Loch Raven Bl.</u> | | 25a. DATE REC'D. BY REGISTRAR
<u>DEC 15 1986</u> | | 25b. REGISTRAR'S SIGNATURE
<u>John E. Johnson</u> | | |

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P 1802 1801

WHITE ISLAND

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|--|--|---|--|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Christine Powell | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 4 86 | | | 2b. HOUR
7:11 PM | | | |
| 3. SEX
F | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
8 21 36 | | 6. AGE (IN YEARS LAST BIRTHDAY)
50 YRS | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN)
COUNTRY
N.C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Francis Scott Key Hosp. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
DISABLED | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
STATE
MD | | | 13b. COUNTY
Balt | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John Brown | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ADELE Bullock | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | | |
| 16b. SOCIAL SECURITY NO.
245-58-349 | | | 17. INFORMANT
Cathy Powell 1610 McCulloh St. | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u>
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 1/2 hours | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:10
<u>Diabetes, Hypertension</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 4</u> , 19 <u>86</u> , to <u>Dec 4</u> , 19 <u>86</u> , that (I) (we) lost
saw the deceased alive on <u>Dec 4</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>M. Fingerhord MD</u> | | | DEGREE | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
12/4/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
M. Fingerhord | | | 22e. ADDRESS
Francis Scott Key Hospital | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | | 23b. DATE
12 10-86 | | 23c. NAME OF CEMETERY OR CREMATORY
EASTVIEW CEM. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTO. MD | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
MARCH FUNERAL HOME 1101 E. NORTH AVE. | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 9 1986 | | 25b. REGISTRAR'S SIGNATURE
<u>John Davidson-Rudolph</u> | | |

DHMH - 16 60M 7/84
(VRA 15, 4)

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 should be detached for use on the burial-transit permit. Their place remains carbon papers. Pages 1 and 2 should be filed with 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified above.

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201



026826 DEC

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|---|--|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT) Florence E. Powell (Mason) | | | 2a. DATE OF DEATH
MONTH 12 DAY 8 YEAR 86 | | 2b. HOUR
12:20 AM |
| 3 SEX
Female | 4 RACE
Black | 5. DATE OF BIRTH
MONTH 07 DAY 16 YEAR 1907 | | 6. AGE (IN YEARS LAST BIRTHDAY)
79 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Baltimore M.D. | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. |
| 10. CITY OR TOWN OF DEATH
Baltimore City | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
University Hospital | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Overemployed | |
| 13a. STATE
M.D. | | | 13b. COUNTY
Baltimore | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST James MIDDLE L. LAST Allen | | | 15. MOTHER'S MAIDEN NAME
FIRST Marry MIDDLE P. LAST HTS | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
212-14-8304 | | 17. INFORMANT
Jeanette Babb ADDRESS
2706 Ellicott Drive | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiopulmonary Arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) Massive Cerebral Vascular Accident
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)
Hypertension Diabetes | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | |
| 21d. INJURY OCCURRED
AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (1) (this hospital) attended the deceased from 12/7 19 86 , to 12/8 19 86 , that (we) lost saw the deceased alive on 12/7 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.) | | | | | |
| 22b. SIGNATURE
Dr. Zhezon M.D. | | DEGREE | | 22c. DATE SIGNED
12/8/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
URI KHAZAN | | 22e. ADDRESS
5802 Woodlawn Run Drive | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
12/10/86 | | 23c. NAME OF CEMETERY OR CREMATORY
Eastview Cemetery | |
| 23d. LOCATION
CITY OR TOWN
Baltimore | | COUNTY | | STATE
Md | |
| 24. FUNERAL DIRECTOR
NAME
March Funeral Home West 4300 Wabash Avenue | | | 25a. DATE REC'D. BY REGISTRAR
DEC 10 1986 | | |
| ADDRESS | | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | |

MEDICAL CERTIFICATION

99

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

BP

[Faint, illegible handwritten text and markings are visible across the page, including what appears to be a signature in the upper left and various scribbles and lines throughout.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 12 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | REG. NO. | |
|---|--|--|--|---|-----------------------------------|--|
| 1. FOR STATE REGISTRAR
DECEASED NAME (TYPE OR PRINT)
Mary Lou Powell | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 20 1986 | | 2b. HOUR
M | |
| 3 SEX
female | 4 RACE
black | 5 DATE OF BIRTH
MONTH DAY YEAR
5 10 1930 | | 6 AGE (IN YEARS (LAST BIRTHDAY))
56 YRS | | IF UNDER 1 YEAR
MONTHS DAYS |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
N.C. | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Baltimore city MD | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
1606 Vincent Court | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md | | 13b. CITY OR TOWN
Baltimore | | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Ed Massenburg | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Sallie WEAVER | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
239-12-5051 | | 17. INFORMANT ADDRESS
Robert Powell 4038 Park Heights Avenue | | |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARDIOVASCULAR DISEASE</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>HYPERTENSIVE HEART DISEASE</u>
(c) <u>COPD</u>
DUE TO, OR AS A CONSEQUENCE OF
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | |
| 21d. INJURY OCCURRED
INJURY <input type="checkbox"/> AT WORK <input type="checkbox"/> NO <input type="checkbox"/> WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost the deceased alive on <u>12-18</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
Warren J. Shima | | | | DEGREE
MD | | 22c. DATE SIGNED
12-22-86 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
WARREN J. SHIMA | | | | 22e. ADDRESS
3502 W ROBERT MD#6 | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
12/23/86 | | 23c. NAME OF CEMETERY OR CREMATORY
Eastview Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Md |
| 24. FUNERAL DIRECTOR
NAME
March Funeral Home West 4300 Wabash Avenue | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 23 1986 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall |

BP _____

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | |
|--|--|---|--|
| FOR
STATE
REGISTER | | 8 6 3 4 8 4 0 | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | 2a. DATE OF DEATH | |
| MARIE H POWERS | | MONTH DAY YEAR | |
| | | 12 10 86 | |
| 3. SEX | | 2b. HOUR | |
| Female | | 4:30 P.M. | |
| 4. RACE | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| White | | 78 YRS. | |
| 5. DATE OF BIRTH | | IF UNDER 1 YEAR | |
| MONTH DAY YEAR | | MONTHS DAYS | |
| 1-9-1908 | | HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| Ireland | | BALTIMORE CITY MD. | |
| 7b. CITIZEN OF WHAT COUNTRY? | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| U.S.A. | | Stenographer | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 10. CITY OR TOWN OF DEATH | | Hotel Co. | |
| BALTIMORE | | | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | |
| UNION MEMORIAL HOSPITAL | | | |
| 13a. STATE | | 13b. COUNTY | |
| Md. | | Baltimore | |
| 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | |
| Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | |
| Owen Foster | | Peter Berns | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | |
| NO | | 212-20-9817 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: | | | |
| IMMEDIATE CAUSE (a) | | RESPIRATORY ARREST | |
| DUE TO, OR AS A CONSEQUENCE OF | | | |
| (b) | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | |
| (c) | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| | | | |
| 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | |
| | | HOUR A.M. MONTH DAY YEAR | |
| | | P.M. 19 | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY | |
| AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/> | | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | |
| 21f. LOCATION | | CITY OR TOWN | |
| | | COUNTY | |
| | | STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from Dec 7, 1986, to Dec 10, 1986, that (I) (we) last saw the deceased alive on Dec 10, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE | | DEGREE | |
| John T. Evelius | | M.D. | |
| 22c. DATE SIGNED | | 12/10/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | |
| JOHN T. EVELIUS, M.D. | | UNION MEMORIAL HOSPITAL | |
| 23a. BURIAL, CREMATION, REMOVAL | | 23b. DATE | |
| Burial | | 12-13-1986 | |
| 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | |
| The Catholic Cem. | | Baltimore | |
| 23e. DATE REC'D. BY REGISTRAR | | 23f. REGISTRAR'S SIGNATURE | |
| 15 1986 | | John T. Evelius | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other unusual condition, the medical examiner must be notified.

05121 12-10-88

[Faint, illegible text covering the majority of the page, possibly bleed-through from the reverse side.]

05121 12-10-88

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and page 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|---|--|--|--|--|--|---|--|--|--|--|--|
| 1. FOR
STATE
REGISTRAR | | DECEASED NAME
(TYPE OR PRINT)
Charles T. Pratt | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12-25-86 | | 2b. HOUR
M | |
| 3. SEX
Male | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
4-8-1939 | | 6. AGE (IN YEARS LAST BIRTHDAY)
47 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
3227 Gwynns Falls Pkwy. | | | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Truck driver. | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
3227 Gwynns Falls Pkwy. 21216 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Thomas Asknew | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Jacobs | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | | 16b. SOCIAL SECURITY NO.
219-32-5392 | | 17. INFORMANT
ADDRESS
Shirley Terrell 3227 Gwynns Falls Pkwy. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest.</u>
DUE TO, OR AS A CONSEQUENCE OF,
(b) <u>Metastatic Bladder Cancer</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>3/12</u> , 19 <u>86</u> , to <u>12/25</u> , 19 <u>86</u> , that (1) (we) lost saw the deceased alive on <u>12/20</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>John H. Fetting M.D.</u> | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
12/29/86 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
John H. Fetting M.D. | | | | 22e. ADDRESS
Johns Hopkins Oncology Center | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
12-30-86 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Md. | | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Brown/Thompson F.H. 1913 W. Baltimore St. | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE
DEC 30 1986 <u>John Terrell</u> | | | |

0507-1000

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. The law requires that the attending physician and the medical examiner must be notified of a death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of a death.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | |
|---|--|---|--|---|---------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MARY MIDDLE SABINA LAST PRECHTEL | | | 2a. DATE OF DEATH
MONTH DAY YEAR
DEC. 28, 1986 | | 2b. HOUR
9:35 AM | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
2 3 23 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 6. AGE (IN YEARS LAST BIRTHDAY)
63
YRS. MONTHS DAYS HOURS MIN. | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
JOHNS HOPKINS HOSPITAL | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE MD. | | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housekeeper | | 12b. KIND OF BUSINESS OR INDUSTRY
School | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Anton Nicholas Widmark | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Marie Valley | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | 16b. SOCIAL SECURITY NO.
219-05-7207 | | 17. INFORMANT
ADDRESS
Mrs. Mary D. Goldburn, 707 S. Decker Avenue
Baltimore, Md. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio Respiratory Arrest
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Stage IV Endometrial Carcinoma
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
mid. day 9 months. | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a
Acute Renal Failure | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12-23, 1986, to 12-28, 1986, that (I) (we) last saw the deceased alive on 12-28, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
V. Cullins, M.D. | | DEGREE | | 22c. DATE SIGNED | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS
Johns Hopkins Hospital 600 N. W. 2229 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
12-31-86 | | 23c. NAME OF CEMETERY OR CREMATORIUM
Sacred Heart of Jesus | | |
| 24. FUNERAL DIRECTOR
Ann S. Matthews, Matthews Funeral Home
3021 Eastern Avenue, Baltimore, Md. 21224 | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Baltimore Md. | | 25a. DATE REC'D. BY REGISTRAR
DEC 30 1986 | | |
| | | | | 25b. REGISTRAR'S SIGNATURE
F. J. Fisher | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | |
|--|--|---|---|--|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Agnes Jeanette Preill | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 15 86 | | 2b. HOUR
3 PM | |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
July 19, 1903 | | 6. AGE (IN YEARS (LAST BIRTHDAY))
83 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD. | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Union Memorial Hospital | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Home maker | 12b. KIND OF BUSINESS OR INDUSTRY
----- | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | |
| 13a. STATE
Maryland | 13b. COUNTY
----- | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
5837 Belair Road 21206 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
George Preill | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Julia Ruth | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
219-40-9255 | | 17. INFORMANT
ADDRESS
Baltimore, MD.
Rita Long 3707 Woodlea Avenue 21206 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CIA</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>MI</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>-----</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>CVA</u> | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (this hospital) attended the deceased from <u>11/9</u> , 19 <u>86</u> , to <u>12/10</u> , 19 <u>86</u> , that (we) lost
saw the deceased alive on <u>12/15</u> , 19 <u>86</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated
above. (If two (or) did not view the body after death. | | | | | | |
| 22b. SIGNATURE
<u>Andrew M. Baer, M.D.</u> | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<u>12/15/86</u> | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Andrew M. Baer, M.D. | | 22e. ADDRESS
Union Memorial Hospital | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | 23b. DATE
12/16/86 | 23c. NAME OF CEMETERY OR CREMATORY
Security Process, Inc. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Co., MD. | |
| 24. FUNERAL DIRECTOR
NAME
Dippel Funeral Homes, Inc.
7110 Belair Road Baltimore, MD. 21206 | | | 25a. DATE REC'D. BY REGISTRAR
DEC 16 1986 | | | 25b. REGISTRAR'S SIGNATURE
<u>Julius Sanders-Randall</u> |

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V.A.

M.S.A.

Chito

Laber

10/11/1911

Transferred to the
Prison House
at the same time as the
other prisoners



After several years of
imprisonment the
prisoner was released

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

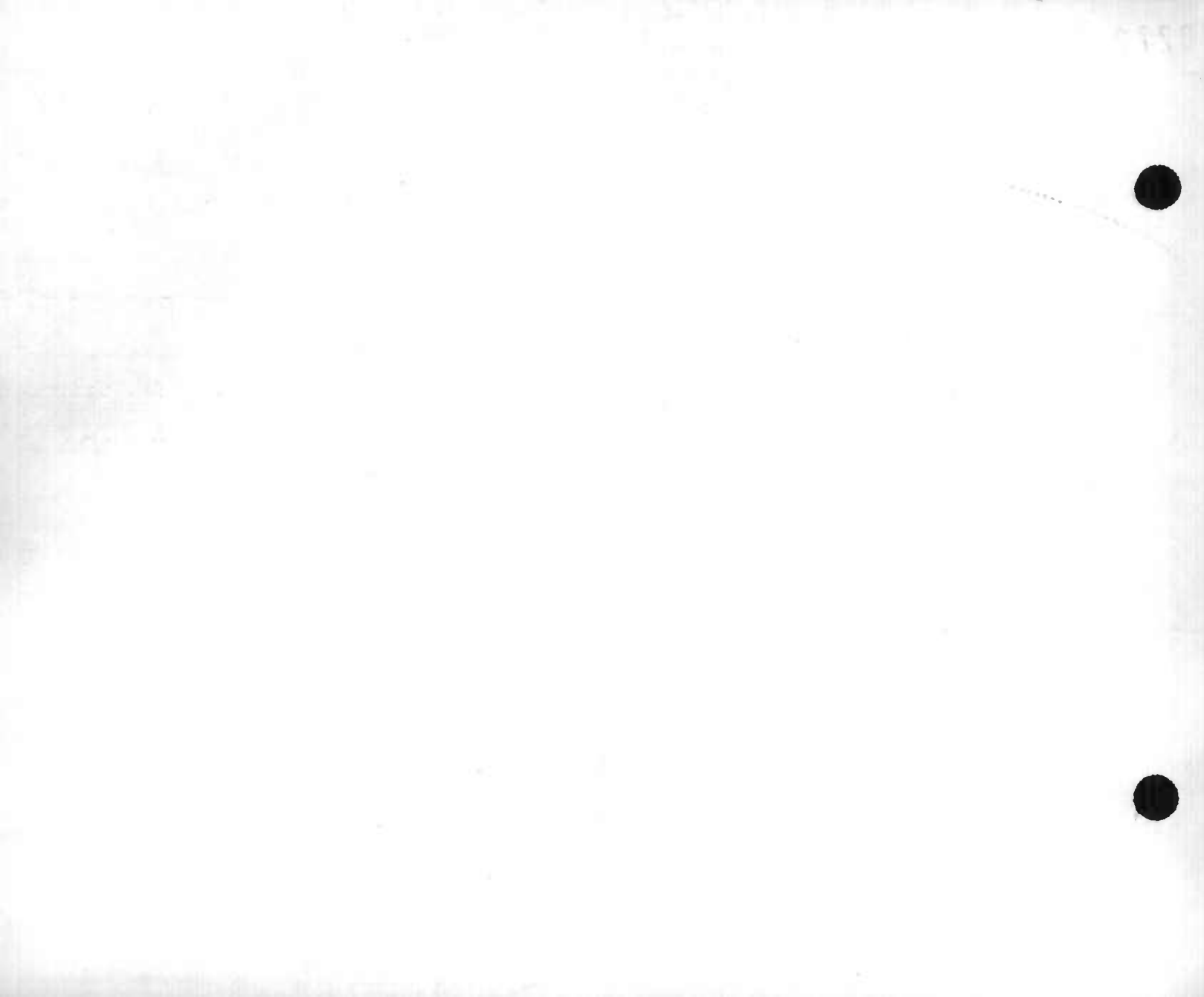
| | | | | | | |
|--|---------------------|---|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Pearl A. Preston | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 12 86 | | 2b. HOUR
10:50 P | |
| 3. SEX
F | 4. RACE
B | 5. DATE OF BIRTH
MONTH DAY YEAR
08 19 20 | 6. AGE (IN YEARS LAST BIRTHDAY)
66 YRS | | 7. # UNDER 1 YEAR
MONTHS DAYS
0 0 | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
TRINIDAD West Indies | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTO CITY MD. | | 10. CITY OR TOWN OF DEATH
BALTO | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN THIS FACILITY, GIVE STREET ADDRESS)
SINAI HOSPITAL |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
N/A | | 12b. KIND OF BUSINESS OR INDUSTRY
NA | | 13a. STATE
MD. | | 13b. COUNTY
Balto. |
| 13c. CITY OR TOWN
Balto. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
6116 Park Heights 21216 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
CHARLES PRESTON | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ROSLAIND PRESTON | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO.
NONE |
| 17. INFORMANT
Norbert Preston | | ADDRESS
3 Methuen St. Trinidad | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of Colon w/ metastases
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____ | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4 months |
| 19a. DATE OF OPERATION
12-11-86 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Carcinoma | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME STREET FACTORY OFFICE FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that he (this hospital) attended the deceased from 11/12 , 19 86 , to 12/12 , 19 86 , that he (we) last saw the deceased alive on 12/12 , 19 86 , and that in our (our) opinion death occurred on the date and hour and from the causes stated above we (we) (did) not view the body after death. | | | | | | |
| 22b. SIGNATURE
SCHULTZ | | DEGREE
PHYSICIAN | | 22c. DATE SIGNED
12/12/86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
SCHULTZ, MICHAEL J. | | 22e. ADDRESS
Suite 14 2435 W. Belvedere Ave 21215 | | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
12/22/86 |
| 23c. NAME OF CEMETERY OR CREMATORY
LAPERUS | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
WOODBROOK, TRINIDAD | | 24. FUNERAL DIRECTOR
NAME ADDRESS
Leroy O. Dyett 4600 Liberty Heights | | 25a. DATE REC'D. BY REGISTRAR
DEC 15 1986 |
| 25b. REGISTRAR'S SIGNATURE
Lelia Preston | | | | | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove contact papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called to examine the body.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | | | |
|--|--|---|--|---|--|---|--|---|--|--|--|------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Helen Vera Price | | | | | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12-30-86 | | 2b. HOUR
1:15 P.M. | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
April 6 1914 | | 6. AGE (IN YEARS LAST BIRTHDAY)
72 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Union Memorial Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Admin. Ass't. | | 12b. KIND OF BUSINESS OR INDUSTRY
U.S.A.F. | | | | | |
| 13a. STATE
Md. | | 13b. COUNTY
Balto. | | 13c. CITY OR TOWN
Balto. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
116 W. Univ. Pkwy. 21210 | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Tilghman M. Price | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
India M. Robinson | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WW 11 | | 17. INFORMANT
ADDRESS
A. Lynne E. Calhoun Annapolis, Md. | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Intracerebral bleed, hyperten, 2° aneurysm / MI | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | | |
| DUE TO, OR AS A CONSEQUENCE OF
(b) _____ | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
HTN | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION
N/A | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED
AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/28 , 19 86 , to 12/30 , 19 86 , that (I) (we) lost
saw the deceased alive on 12/30 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (do not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE
Frank G. Tuzzi | | | | DEGREE
MD
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED
12/30/86 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Frank A Tuzzi MD | | | | 22e. ADDRESS
Union Memorial Hospital | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | 23b. DATE
12-30-86 | | 23c. NAME OF CEMETERY OR CREMATORY
Greenmount | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto. MD. | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Henry W. Jenkins & Sons Co., Balto., Md. | | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 31 1986 | | 25b. REGISTRAR'S SIGNATURE
Julia Anderson-Rodgers | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and the official

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | REG. NO. | |
|--|--|---|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Mr. Irvin Ellsworth Price | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 12 86 | | 2b. HOUR
6:00 AM | |
| 3. SEX
Male | 4. RACE
Caucasian | 5. DATE OF BIRTH
MONTH DAY YEAR
12 25 06 | | 6. AGE (IN YEARS LAST BIRTHDAY)
79 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
United States | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Edgewood Nursing Home | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Purchasing Manager | | 12b. KIND OF BUSINESS OR INDUSTRY
Company Commercial Credit | |
| 13a. STATE
Maryland | | | 13b. COUNTY
Baltimore | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William James Price | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Isabel Paynter | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
212-01-7006 | | 17. INFORMANT
Mrs. Margaret Price | | |
| | | | | ADDRESS 21 Gwynn Lake Drive Balto., MD. 21207 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Pneumonia</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>PARKINSONISM</u>
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 1986</u> to <u>Dec 1986</u> , that (I) (we) lost
saw the deceased alive on <u>Dec 2</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
<u>[Signature]</u> | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
C. B. [Signature] | | | | 22e. ADDRESS
5218 Spring Ave Way | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
12/15/86 | | 23c. NAME OF CEMETERY OR CREMATORY
Granite Presbyterian Church | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Granite Baltimore Maryland |
| 24. FUNERAL DIRECTOR
NAME Loring Byers Funeral Directors, Inc.
8728 Liberty Road Randallstown, MD. 21133 | | | | 25. DATE REC'D BY REGISTRAR
DEC 18 1986 | | |

BP _____

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REC 1 P 000

026971 DEC 15 1986

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|---|---|--|--|--|-----------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | 2a. DATE OF DEATH
MONTH DAY YEAR | | | 2b. HOUR | |
| MARGARET W. PRICE | | | DECEMBER 6, 1986 | | | 6:25A M | |
| 3 SEX | 4 RACE | 5. DATE OF BIRTH
MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | | | IF UNDER 1 YEAR
MONTHS DAYS | |
| Female | White | 6-17-1885 | 101 YRS. | | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | |
| Wales | U.S.A. | | Baltimore City MD. | | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Baltimore | Church Hospital | | Homemaker | | | --- | |

| | | | | |
|---|-------------|---|---|--|
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE | |
| 13a. STATE | 13b. COUNTY | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | Broadview Apartments 21210 | |
| Maryland | --- | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | |
| Richard D. Williams | | | Mary Michael | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS | |
| No | | 220-44-0384 | Wm. R. Price 300 Dunkirk Road 21212 | |

| | | | |
|--|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PNEUMONIA | | | |
| DUE TO, OR AS A CONSEQUENCE OF
(b) RENAL FAILURE | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) CONGESTIVE HEART FAILURE | | | |

| | | | |
|--|--|--|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| | | | |
| 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR | |
| | | P.M. 19 | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>OCTOBER 4</u> 19 <u>86</u> to <u>DECEMBER 6</u> 19 <u>86</u> that (I) (we) lost
saw the deceased give up the <u>DECEMBER 6</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) did (did not) view the body after death. | | | |
| 22b. SIGNATURE | | DEGREE | |
| <i>[Signature]</i> | | MD | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | |
| Jonathan D. Kushner | | 100 N. Broadway Balto. Md 21231 | |

| | | | | |
|--|--|--|------------------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION
CITY OR TOWN COUNTY STATE |
| Burial | | 12-8-86 | Chestnut Grove | Sweet Air Baltimore Maryland |
| 24. FUNERAL DIRECTOR
NAME ADDRESS | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE | | |
| Mitchell-Wiedefeld Home 6500 York Road 21212 | | DEC 11 1986 <i>[Signature]</i> | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove all other papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and it should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene. **IMPORTANT:** If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
REG. NO. 8634849
KW PRO CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT)
THOMAS Morris Price, Sr. | | | | 2a. DATE OF DEATH MONTH DAY YEAR
12/7/86 | | | | 2b. HOUR
5:00 M | |
| 3. SEX
M Male | | 4. RACE
W White | | 5. DATE OF BIRTH MONTH DAY YEAR
7 23 1908 | | 6. AGE (IN YEARS LAST BIRTHDAY)
78 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
West Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Church Hospital Inc. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Electrician | | 12b. KIND OF BUSINESS OR INDUSTRY
Closures Mfr. | |
| 13a. STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Dundalk | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
8211 Dogwood Rd./21222 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Darius Clarke Price | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Alice Maude Morris | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)
216/10/5188 | | 17. INFORMANT ADDRESS
Emma E. Price (same as 13e.) | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) respiratory failure
DUE TO, OR AS A CONSEQUENCE OF (b) pneumonia (+ pseudomonas in sputum)
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
organic heart disease | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Shirley G. Allen, M.D. | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Thomas G. Allen | | | | 22e. ADDRESS
Church Hospital | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
12/10/1986 | | 23c. NAME OF CEMETERY OR CREMATORY
Meadowridge Mem. Park | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Elkridge, Maryland | | | |
| 24. FUNERAL DIRECTOR NAME
Walter Brooks Bradley Inc. | | | | ADDRESS
Balto., Md. 21222 | | 25a. DATE REC'D. BY REGISTRAR
DEC 9 1986 | | 25b. REGISTRAR'S SIGNATURE
John F. ... | |

BP

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10/2/60

026566 DEC 1986

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | | | | | |
|---|--|--|--|---|--|---|--|---|--|
| FOR
1. STATE
REGISTRAR | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | | | |
| DECEASED NAME
(TYPE OR PRINT)
CHESTER MORRIS PRITCHETT | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 / 5 / 86 | | | 2b. HOUR
8:00 PM | | | |
| 3. SEX
male | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
7-15-1945 | | 6. AGE
(IN YEARS LAST BIRTHDAY)
41 YRS | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNION MEMORIAL HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF LIFE)
Laborer | | 12b. KIND OF BUSINESS OR INDUSTRY
Construction | |
| 13a. STATE
md | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
442 E 22nd St Baltimore, Md 21218 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Vance Pritchett | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Clory Harrison | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(IF NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
216-42-6765 | | 17. INFORMANT
Name Address
Juanita Pritchett Baltimore, Md 21218 | | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Pontine Hemorrhage</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Hypertension</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Alcoholism</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/5</u> , 19 <u>86</u> , to <u>12/5</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>12/5</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>S.O. Trerutola MD</u> | | | | DEGREE
MD | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12/5/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
S.O. Trerutola MD | | | | 22e. ADDRESS
UNION MEMORIAL HOSPITAL | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
12/11/86 | | 23c. NAME OF CEMETERY OR CREMATORY
Garrison Forest | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Crown Mills Balt. Md | | | |
| 24. FUNERAL DIRECTOR
Name Address
Winnell B. Allen - 1631 David Hill Ave | | | | 25a. REC'D. BY REGISTRAR
DEC 8 1986 | | 25b. REGISTRAR'S SIGNATURE
Julia Darden-Rodden | | | |

[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page.]



027283 DEC

Item #, / G-622, / 12/24/86 by
 FOR F.H., / Gbj.
 STATE
 REGISTRAR
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

REG. NO.

34851

| | | | | | | | |
|--|--|---|---|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
VIRGIE ARLINGTON PROCTOR | | | 2a. DATE OF DEATH
MONTH DAY YEAR
DECEMBER 13, 1986 | | | 2b. HOUR
2:30 P.M. | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
SEP. 13, 1922 | | 6. AGE (IN YEARS LAST BIRTHDAY)
64 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
NORTH CAROLINA | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNIVERSITY OF MARYLAND HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Self-Employed (RET.) Grocery Store | |
| 13a. STATE
Maryland | | 13b. COUNTY
City | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Walter R. COGGIN | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Willie Portress | | 13e. STREET ADDRESS / ZIP CODE
312 South Pulaski Street 21223 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
N/A | | 17. INFORMANT
ADDRESS
Mr. D. Wright Proctor 312 S. Pulaski St. 21223 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) respiratory depression
DUE TO, OR AS A CONSEQUENCE OF
(b) squamous cell CA of cervix
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
severe dehydration | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/9 , 19 86 , to 12/13/86 , 19 86 , that (I) (we) last saw the deceased alive on 12/13 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
J. ROSENTHAL | | DEGREE
MD
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED
12/13/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
J. ROSENTHAL | | 22e. ADDRESS
22. S. Greene St. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
16 DEC'86 | | 23c. NAME OF CEMETERY OR CREMATORY
Forest Hill Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Nashville Nash N.C. | |
| 24. FUNERAL DIRECTOR
NAME
HUBBARD FUNERAL HOME, INC. Baltimore, Maryland | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 15 1986 | | 25b. REGISTRAR'S SIGNATURE
Julia... | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be submitted to the hospital or attending physician within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

12842

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NOV 11 1950

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8 6 5 4 3 2 1

FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | | | | | | | | | | |
|---|--|---|--|--|----------------|---|---|--|---------------|--|-------------------|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST
VIRGINIA | | MIDDLE
A | LAST
PURVIS | | 20. DATE OF DEATH
MONTH
DECEMBER 29, 1986 | | 21. DAY
29 | | 22. HOUR
9:33P | | | | | | | | |
| 3. SEX
female | | 4. RACE
black | | 5. DATE OF BIRTH
MONTH
1 | | DAY
21 | | YEAR
31 | | 6. AGE (IN YEARS LAST BIRTHDAY)
55 YRS. | | 7. IF UNDER 1 YEAR
MONTHS
DAYS | | 8. IF UNDER 24 HRS.
HOURS
MIN. | | | | | |
| 9. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
Md | | 10. CITIZEN OF WHAT COUNTRY?
USA | | 11. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 12. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY | | 13. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY | | 14. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY | | 15. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY | | 16. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY | | | | | |
| 17. CITY OR TOWN OF DEATH
BALTIMORE | | 18. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
THE JOHNS HOPKINS HOSPITAL | | 19. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 20. KIND OF BUSINESS OR INDUSTRY | | 21. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md | | 22. COUNTY
BALTO | | 23. CITY OR TOWN
BALTO | | 24. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 25. STREET ADDRESS / ZIP CODE
5816 Glenkirk Ct 21230 | | 26. FATHER'S NAME
FIRST
Leory | | 27. MOTHER'S MAIDEN NAME
FIRST
Ethel | | 28. ADDRESS
Johnson | | 29. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 30. SOCIAL SECURITY NO.
217 24 7139 | | 31. INFORMANT
Harriet Sharp | | 32. ADDRESS
5816 Glenkirk Ct 21230 | | | | | |
| 33. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u> | | 34. DUE TO, OR AS A CONSEQUENCE OF
(b) <u>METASTATIC CANCER</u> | | 35. DUE TO, OR AS A CONSEQUENCE OF
(c) <u>BREAST CANCER</u> | | 36. APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
30 minutes | | 37. APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
2 years | | 38. APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
2 years | | 39. APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
2 years | | 40. APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
2 years | | | | | |
| 41. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL ILLNESS OR CONDITION GIVEN IN PART 1:
<u>COPD</u> | | 42. DATE OF OPERATION
1986 | | 43. CONDITION FOR WHICH OPERATION WAS PERFORMED
1986 | | 44. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 45. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 46. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 47. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 48. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 49. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 50. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 51. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
19 | | 52. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
19 | | 53. LOCATION
STREET CITY OR TOWN COUNTY STATE
19 | | 54. I certify that (I) (this hospital) attended the deceased from <u>December 23</u> , 19 <u>86</u> , to <u>December 29</u> , 19 <u>86</u> , that (I) (we) last
saw the deceased alive on <u>December 29</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | 55. SIGNATURE
<u>Robert A. Luke MD</u> | | 56. DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 57. DATE SIGNED
12/29/86 | | | |
| 58. PHYSICIAN'S NAME (TYPE OR PRINT)
ROBERT A. LUKE, MD | | 59. ADDRESS
JOHNS HOPKINS HOSPITAL | | 60. BURIAL, CREMATION, REMOVAL
(SEE INSTRUCTIONS) | | 61. DATE
1/5/86 | | 62. NAME OF CEMETERY OR CREMATORY
BALTO Cem | | 63. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE CITY | | 64. FUNERAL DIRECTOR
NAME
Wm. C. March F/H | | 65. ADDRESS
1101 E. North Avenue | | 66. DATE REC'D. BY REGISTRAR
JAN 2 1987 | | 67. REGISTRAR'S SIGNATURE
<u>Julia T. ...</u> | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or either traumatic event, the medical examiner must be notified at once.

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 | 32 | 33 | 34 | 35 | 36 | 37 | 38 | 39 | 40 | 41 | 42 | 43 | 44 | 45 | 46 | 47 | 48 | 49 | 50 | 51 | 52 | 53 | 54 | 55 | 56 | 57 | 58 | 59 | 60 | 61 | 62 | 63 | 64 | 65 | 66 | 67 | 68 | 69 | 70 | 71 | 72 | 73 | 74 | 75 | 76 | 77 | 78 | 79 | 80 | 81 | 82 | 83 | 84 | 85 | 86 | 87 | 88 | 89 | 90 | 91 | 92 | 93 | 94 | 95 | 96 | 97 | 98 | 99 | 100 |
|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|-----|

Handwritten notes and symbols, possibly a signature or initials.

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| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 | 32 | 33 | 34 | 35 | 36 | 37 | 38 | 39 | 40 | 41 | 42 | 43 | 44 | 45 | 46 | 47 | 48 | 49 | 50 | 51 | 52 | 53 | 54 | 55 | 56 | 57 | 58 | 59 | 60 | 61 | 62 | 63 | 64 | 65 | 66 | 67 | 68 | 69 | 70 | 71 | 72 | 73 | 74 | 75 | 76 | 77 | 78 | 79 | 80 | 81 | 82 | 83 | 84 | 85 | 86 | 87 | 88 | 89 | 90 | 91 | 92 | 93 | 94 | 95 | 96 | 97 | 98 | 99 | 100 |
|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|-----|

Handwritten notes and symbols, possibly a signature or initials.

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|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|-----|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 | 32 | 33 | 34 | 35 | 36 | 37 | 38 | 39 | 40 | 41 | 42 | 43 | 44 | 45 | 46 | 47 | 48 | 49 | 50 | 51 | 52 | 53 | 54 | 55 | 56 | 57 | 58 | 59 | 60 | 61 | 62 | 63 | 64 | 65 | 66 | 67 | 68 | 69 | 70 | 71 | 72 | 73 | 74 | 75 | 76 | 77 | 78 | 79 | 80 | 81 | 82 | 83 | 84 | 85 | 86 | 87 | 88 | 89 | 90 | 91 | 92 | 93 | 94 | 95 | 96 | 97 | 98 | 99 | 100 |
|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|-----|

Handwritten notes and symbols, possibly a signature or initials.

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|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|-----|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 | 32 | 33 | 34 | 35 | 36 | 37 | 38 | 39 | 40 | 41 | 42 | 43 | 44 | 45 | 46 | 47 | 48 | 49 | 50 | 51 | 52 | 53 | 54 | 55 | 56 | 57 | 58 | 59 | 60 | 61 | 62 | 63 | 64 | 65 | 66 | 67 | 68 | 69 | 70 | 71 | 72 | 73 | 74 | 75 | 76 | 77 | 78 | 79 | 80 | 81 | 82 | 83 | 84 | 85 | 86 | 87 | 88 | 89 | 90 | 91 | 92 | 93 | 94 | 95 | 96 | 97 | 98 | 99 | 100 |
|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|-----|

Handwritten notes and symbols, possibly a signature or initials.

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|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|-----|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 | 32 | 33 | 34 | 35 | 36 | 37 | 38 | 39 | 40 | 41 | 42 | 43 | 44 | 45 | 46 | 47 | 48 | 49 | 50 | 51 | 52 | 53 | 54 | 55 | 56 | 57 | 58 | 59 | 60 | 61 | 62 | 63 | 64 | 65 | 66 | 67 | 68 | 69 | 70 | 71 | 72 | 73 | 74 | 75 | 76 | 77 | 78 | 79 | 80 | 81 | 82 | 83 | 84 | 85 | 86 | 87 | 88 | 89 | 90 | 91 | 92 | 93 | 94 | 95 | 96 | 97 | 98 | 99 | 100 |
|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|-----|

Handwritten notes and symbols, possibly a signature or initials.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | |
|---|--|---|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
John Queen Queen | | | 2a. DATE OF DEATH
MONTH DAY YEAR
December 21, 1986 | | 2b. HOUR
9:30 A | |
| 3. SEX
M | | 4. RACE
B | | 5. DATE OF BIRTH
MONTH DAY YEAR
DEB 22 1919 | | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
67 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | 8. IF UNDER 24 HRS. | | |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md | | 10. CITIZEN OF WHAT COUNTRY?
Baltimore U.S.A | | 11. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | |
| 12. CITY OR TOWN OF DEATH
Baltimore | | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Maryland General Hospital | | 14. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Steel Mill | | |
| 15. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
15a. STATE
Md | | 15b. COUNTY
Baltimore | | 15c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 16. FATHER'S NAME
FIRST MIDDLE LAST
Junior Queen | | 17. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Louise Chambers | | 18. STREET ADDRESS / ZIP CODE
2437 Callow Ave 21217 | | |
| 19a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 19b. SOCIAL SECURITY NO.
WW1 220 07 9263 | | 19c. INFORMANT
ADDRESS
Alma Cropper 1804 E. Copeland St Annapolis, Md | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cancer Of Rectum With Probable Metastasis
DUE TO, OR AS A CONSEQUENCE OF
Uremia
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
Renal Failure
(c) _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK
AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that <input checked="" type="checkbox"/> this hospital attended the deceased from December 2 , 19 86 , to December 21 , 19 86 , that <input checked="" type="checkbox"/> (we) lost
saw the deceased alive on December 21 , 19 86 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated
above. <input checked="" type="checkbox"/> (we) did not view the body after death. | | | | | | |
| 22b. SIGNATURE
M.D. PERRY, D.O. | | | | | 22c. DATE SIGNED
12/21/86 | |
| 22d. PHYSICIAN'S SIGNATURE (TYPE OR PRINT)
M.D. PERRY, D.O. | | | | | 22e. ADDRESS
C/o Maryland General Hospital | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
12-29-1986 | | 23c. NAME OF CEMETERY OR CREMATORY
MD Veterans | | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Crownsville A.A. Md | | 24. FUNERAL DIRECTOR
NAME ADDRESS
C. E. Hicks, 111 1922 Forest Drive Annapolis, Md | | 25a. DATE REC'D. BY REGISTRAR
DEC 29 1986 | | |
| | | | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | |

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(continued)

J28072 DEC 29 1986

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | | |
|---|---------|---|--|--|--|---|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH | | | | 2b. HOUR | | | |
| MAGGIE | | | | | | QUEEN | | <input checked="" type="checkbox"/> MONTH
<input type="checkbox"/> DAY
<input type="checkbox"/> YEAR | | | | 12 18 1986
M | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | 8. MONTH DAY YEAR | | 9. HOUR | | | |
| F | B | 3 25 05 | | 81 YRS. | | | | 12 18 1986 | | 9:18 | | A M | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | |
| MD | | USA | | | | Baltimore City MD | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Baltimore | | 1748 N. Gay St. | | | | ? | | | | | | | | | |
| 13a. STATE | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | |
| MD | | | | | | BALTIMORE | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 1748 N. GAY STREET 21213 | | | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | |
| ALBERT SUMMERS | | | | UNK. | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | | | | | |
| NO | | | | 213264543 | | MABLE MASON 1700 COLLINGTON AVE. 21213 | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. | | | | | | | | | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? | | | |
| | | | | | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| | | | | P.M. 19 | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | TITLE (SPECIFY) | | | | DATE SIGNED | | | | | | | |
| Charles P. Kokes, M.D. | | | | M.D. Assistant MEDICAL EXAMINER | | | | 12-18-86 | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS | | | | | | | | | | | |
| Charles P. Kokes, M.D. | | | | 111 Penn St., Balto., MD 21201 | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | |
| BURIAL | | | | 12-23-86 | | MARYLAND NATIONAL MEM. | | | | LAUREL MD | | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| MARCH FUNERAL HOME 1101 E. NORTH AVE. | | | | | | DEC 21 1986 | | John Davidson-Kendall | | | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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026929 DEC 12 86

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 3 4 8 5 5

REG. NO.

| | | | | | | | | | | | |
|--|--|--|---|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
JAMES | | | FIRST MIDDLE LAST
QUILLE, JR | | | 2a. DATE OF DEATH MONTH DAY YEAR
12 - 7 - 86 | | | 2b. HOUR
1:57 P | | |
| 3. SEX
MALE | | | 4. RACE
BLACK | | | 5. DATE OF BIRTH MONTH DAY YEAR
01 17 38 | | | 6. AGE (IN YEARS LAST BIRTHDAY)
- 48 - YRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | |
| 10. CITY OR TOWN OF DEATH
BALTO. | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNIVERSITY HOSP. | | | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
CONSTRUCTION | | |
| 13a. STATE
MD | | | 13b. COUNTY
BALTO. | | | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13d. STREET ADDRESS / ZIP CODE
1801 Whitmore Ave. 21216 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
James | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Honey Sprue | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | | 16b. SOCIAL SECURITY NO.
216 34 5030 | | |
| 17. INFORMANT ADDRESS
DORETHA W. Quille 1801 Whitmore Ave. | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) INTRACEREBRAL HEMATOMA
DUE TO, OR AS A CONSEQUENCE OF
(b) HYPERTENSION
DUE TO, OR AS A CONSEQUENCE OF
(c) -
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a
NO CEREBRAL BLOOD FLOW PER NUCLEAR CEREBRAL ANGIOGRAM | | | | | | | | | | | |
| 19a. DATE OF OPERATION
12/3/86 | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
INTRACEREBRAL HEMATOMA | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 12 - 3 1986 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/3/86 to 12/7/86, that (I) (we) last saw the deceased alive on 12/3/86, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Kevin B. Gerold, MD | | | DEGREE | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
12/7/86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
KEVIN B GEROLD | | | 22e. ADDRESS
2250 GREENE ST, BALTO, MD | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | | 23b. DATE
12 11 86 | | | 23c. NAME OF CEMETERY OR CREMATORY
GARRISON FOREST | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
OWINGS MILLS MD | | |
| 24. FUNERAL DIRECTOR
MARCH FUNERAL HOME | | | 25a. DATE REC'D. BY REGISTRAR
DEC 10 1986 | | | 25b. REGISTRAR'S SIGNATURE
Lia Dendron-Rudolph | | | | | |

MEDICAL CERTIFICATION

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9
9
9

IMPORTANT: If item 21 is marked or item 18 shows any injury, or after a traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

RECEIVED 1938

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 3 4 8 5 0

REG. NO.

| | | | | | |
|---|---|---|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
NAPRE DaSilva QUINN | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 28 86 | | 2b. HOUR
1150 PM |
| 3. SEX
Female | 4. RACE
CAUCASIAN | 5. DATE OF BIRTH
MONTH DAY YEAR
10 30 07 | | 6. AGE (IN YEARS LAST BIRTHDAY)
79 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Portugal | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore City | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SINAI HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
MD | | | 13b. COUNTY
BALT. CITY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Unknown | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Unknown | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
217-46-0772 | | 17. INFORMANT
ADDRESS
John R. Quinn 7 Katie Ct. Timonium, Md.
21093 | |

| | | |
|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) <u>Lung Infection - pneumonia</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|--|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)

| | | | |
|--|--|--|--|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I, (us) (hospital)) attended the deceased from <u>12/15</u> 19 <u>86</u> , to <u>12/29</u> 19 <u>86</u> , that (I, (we)) last saw the deceased alive on <u>12/28</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did (did not) view the body after death.) | | | |
| 22b. SIGNATURE
<u>[Signature]</u> 9008 MD | | 22c. DATE SIGNED
12/29/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
WERTHEIMER | | 22e. ADDRESS
5847 B W-STEIN RUN DC, BALT 21209 | |

| | | | |
|--|-----------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
12-30-86 | 23c. NAME OF CEMETERY OR CREMATORY
Dulaney Valley Mem. | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Cockeysville Balto. Md. |
|--|-----------------------|---|---|

| | | |
|--|--|--|
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Eline Funeral Home Reisterstown, Md. | 25a. DATE REC'D. BY REGISTRAR
DEC 31 1986 | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> |
|--|--|--|

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 is marked, injury, or other traumatic event, the medical examiner must be notified.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or other final disposition. If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 34857 | | | | | | | | | |
|--|--|--|--------------------|--|--|--|--|--|--|--|--|---|--|--|---|--------------------------------|--|--------------------------------|--|
| 1. FOR STATE REGISTRAR | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 12 26 86 | | | | | | | 2b. HOUR 12:45A M | | | | | | | |
| 1. DECEASED NAME FIRST MIDDLE LAST
FREDERICK CLAYTON RABER | | | | | 3. SEX MALE | | | | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 12 17 16 | | 6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS | | 7. IF UNDER 1 YEAR MONTHS DAYS | | 7b. IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2050 Grinnalds Avenue | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Maintenance | | | | | 12b. KIND OF BUSINESS OR INDUSTRY Bindery Optic | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 2050 Grinnalds Avenue 21230 | | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William Raber | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elsie Meyer | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | | | | 16b. SOCIAL SECURITY NO. Ww II 218-10-1496 | | 17. INFORMANT ADDRESS Elizabeth F. Raber 2050 Grinnalds Ave. 21230 | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Hepatic Failure.</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Liver Metastases</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Colon Cancer</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>2 wks</u>
<u>14 mo</u>
<u>2 yrs</u> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9/3</u> , 19 <u>85</u> , to <u>12/26</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>12/18</u> , 19 <u>86</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE <u>Wm C Waterfield</u> | | | | | 22c. DATE SIGNED <u>12-29-86</u> | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) William Waterfield | | | | | 22e. ADDRESS St. Agnes Hospital Oncology Dept. | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 12/29/86 | | 23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC. ADDRESS 4107 WILKENS AVE. | | | | | 25a. DATE REC'D. BY REGISTRAR DEC 29 1986 | | 25b. REGISTRAR'S SIGNATURE <u>Julia Swanson-Randall</u> | | | | | | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body. **IMPORTANT:** If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | |
|--|--|---|--|---|---|---|---|--|--|----------------------|
| 1. FOR STATE REGISTRAR | | 26199 DEC -5 | | | | REG. NO. 34858 | | | | |
| 1. DECEASED NAME (PRINT)
FIRST MIDDLE LAST
LOUIS L. RACHANOW | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
12 3 86 | | | | | 2b. HOUR
740 P.M. |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
02 26 21 | | 6. AGE (IN YEARS LAST BIRTHDAY)
65 YRS | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Sinai Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Traffic Manager | | 12b. KIND OF BUSINESS OR INDUSTRY
U. S. Government | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
STATE CITY COUNTY
Maryland Baltimore Catonsville | | | | | 13b. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13c. STREET ADDRESS / ZIP CODE
1215 McCurdy Avenue 21228 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Samuel Rachanow | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Isabelle Kerns | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
213-14-4700 | | 17. INFORMANT
Elsie Rachanow | | | ADDRESS
Same as # 13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardio pulmonary Arrest</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic Breast Ca.</u>
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
R. Keren MD | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED
12/3/86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
R. KEREN | | | | 22e. ADDRESS
SINAI HOSPITAL Baltimore, MD. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
12/6/86 | | 23c. NAME OF CEMETERY OR CREMATORY
New Cathedral Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Maryland | | | | |
| 24. FUNERAL DIRECTOR
NAME
Lero M. & Russell C. Witzke Funeral Homes P.A.
1630 Edmondson Avenue, Catonsville, MD. 21228 | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 4 1986 | | 25b. REGISTRAR'S SIGNATURE
A. Davidson-Randall | | | | |

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | |
|--|--|--|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
<i>William J Raftery</i> | | | 2a. DATE OF DEATH
MONTH DAY YEAR
<i>12 19 86</i> | | 2b. HOUR
<i>955p</i> | |
| 3. SEX
<i>M</i> | | 4. RACE
<i>C</i> | | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>12 07 21</i> | | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
<i>65</i> | | IF UNDER 1 YEAR
MONTHS DAYS
<i>YRS</i> | | IF UNDER 24 HRS
HOURS MIN.
<i>YRS</i> | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>MD USA</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>US</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Baltimore City</i> | | 10. CITY OR TOWN OF DEATH
<i>Baltimore</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>University of Maryland</i> | | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Retired</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>US Post Office</i> | | 13a. STREET ADDRESS / ZIP CODE
<i>Rodo Beach 20687</i> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>DANIEL</i> | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>IDA GALBRAITH</i> | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>NO</i> | | |
| 16b. SOCIAL SECURITY NO.
<i>43 12 4643</i> | | 17. INFORMANT
ADDRESS
<i>MARGUERITE C. RAFTERY</i> | | 18. SAME AS 13E. | | |
| 19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Respiratory Arrest</i>
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Klebsiella Pneumonia + Sepsis</i>
DUE TO, OR AS A CONSEQUENCE OF (c) <i>enterocutaneous Fistula</i> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>35 min</i>
<i>48 hrs</i> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | |
| 19a. DATE OF OPERATION
<i>12-14-86</i> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
<i>Upper GI Bleed</i> | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | |
| 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>12/12</i> 19 <i>86</i> , to <i>12/19</i> 19 <i>86</i> , that (I) (we) last saw the deceased alive on <i>12/19</i> 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22a. SIGNATURE
<i>SE Thomas MD</i> | | DEGREE
<i>MD</i> | | 22c. DATE SIGNED
<i>12-19-86</i> | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>SE Thomas</i> | | 22e. ADDRESS
<i>22 S. Green St Baltimore MD 21201</i> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<i>BURIAL</i> | | 23b. DATE
<i>12/22/86</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>ST. MICHAELS CEM.</i> | | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>RIDGE ST. MARY'S MD</i> | | 24. FUNERAL DIRECTOR
NAME
<i>Mattingly's</i> | | | | |
| 25a. DATE REC'D. BY REGISTRAR
<i>DEC 24 1986</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Julia Sinden-Rudman</i> | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT - If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0 3 4 8 0 0

REG. NO.

1. FOR
STATE
REGISTRAR1. DECEASED NAME
(TYPE OR PRINT)FIRST MIDDLE LAST
Frances M Raither2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR
12 9 86 5 28 M3. SEX
Female4. RACE
White5. DATE OF BIRTH
MONTH DAY YEAR
01 05 18976. AGE (IN YEARS LAST BIRTHDAY) 7. UNDER 1 YEAR 8. UNDER 2 HRS.
89 YRS. MONTHS DAYS HOURS MIN.7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland7b. CITIZEN OF WHAT COUNTRY?
USA8. MARRIED ☐ NEVER MARRIED ☐
WIDOWED ☒ DIVORCED ☐9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD.10. CITY OR TOWN OF DEATH
Baltimore11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Union Memorial Hospital12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife 12b. KIND OF BUSINESS OR INDUSTRY
HomemakingUSUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE 13b. COUNTY 13c. CITY OR TOWN
Maryland Baltimore13d. INSIDE CITY LIMITS? YES ☐ NO ☒ 13e. STREET ADDRESS / ZIP CODE
7607 Daniel Avenue 2123414. FATHER'S NAME FIRST MIDDLE LAST
Joseph Kalal15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Ann16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No16b. SOCIAL SECURITY NO.
213-07-0955D17. INFORMANT ADDRESS
John A. Raither 7607 Daniels Avenue 2123418. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory Failure
DUE TO, OR AS A CONSEQUENCE OF
(b) COPD
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 weeksPART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
biliary obstruction, possible carcinoma
19a. DATE OF OPERATION
11/7/86
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
fracture of R hip
20a. AUTOPSY? YES ☐ NO ☒ 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)
21d. INJURY OCCURRED
WHITE ☐ NOT WHITE ☐ AT WORK ☐ AT HOME ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION STREET CITY OR TOWN COUNTY STATE
19 81 to 12/9 19 86
22a. I certify that (1) this hospital attended the deceased from 19 81 to 12/9 19 86, that (1) (we) last saw the deceased alive on 12/9 19 86, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) did not view the body after death.
22b. SIGNATURE DEGREE
Stuart B. Bell M.D.
22c. DATE SIGNED
12/9/86
22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Stuart B. Bell, M.D.
22e. ADDRESS
Union Memorial Hospital
ATTENDING MEDICAL STAFF
PHYSICIAN ☒ DIRECTOR ☐ PHYSICIAN ☐23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial 23b. DATE
12-13-86 23c. NAME OF CEMETERY OR CREMATORY
Meadowridge Cemetery 23d. LOCATION CITY OR TOWN COUNTY STATE
Baltimore, Maryland24. FUNERAL DIRECTOR NAME
Lassohn Funeral Home 24a. ADDRESS
4401 Belmar Rd. BALTO. MD. 21236 25a. DATE REC'D. BY REGISTRAR
DEC 11 1986 25b. REGISTRAR'S SIGNATURE
Kelia Gordon-Randall

026988 DEC 15 1986

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

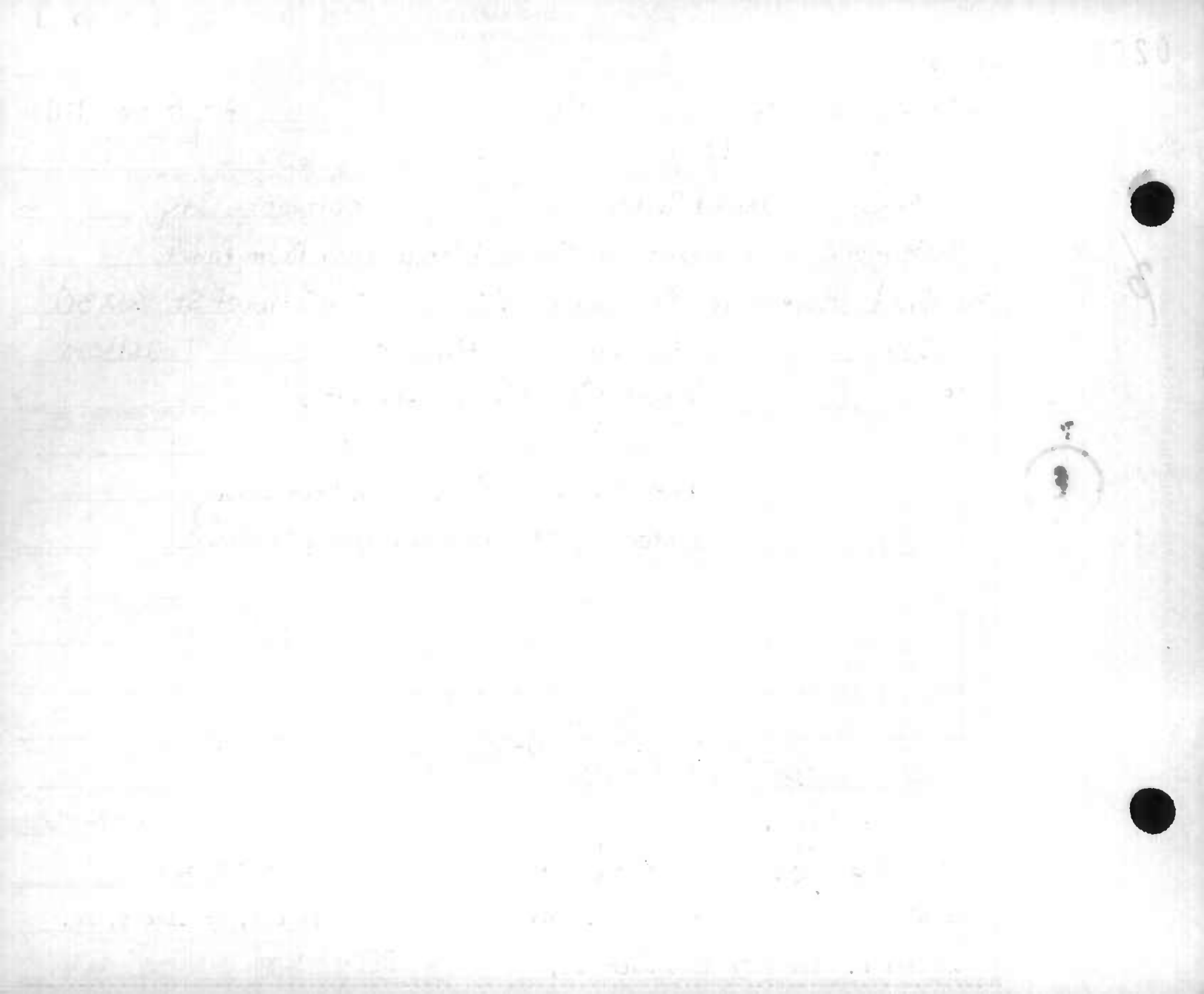
REG. NO.

| | | | | | | | | |
|--|--|--|--|---|--|--|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
Eurskin Eurskine Ramey | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12-7-86 | | | 2b. HOUR
1:11 AM | | |
| 3. SEX
Male | | 4. RACE
Negro | | 5. DATE OF BIRTH
MONTH DAY YEAR
6 3 23 | | 6. AGE (IN YEARS LAST BIRTHDAY)
63 YRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
N.C. | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
South Baltimore General Hosp. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Dover Poultry Products | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Maryland | | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John Ramey | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Maude Wilson | | | 13e. STREET ADDRESS / ZIP CODE
2613 Puget St. 21230 | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
246461965 | | 17. INFORMANT
ADDRESS
Chart John Ramey | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio-Pulmonary Arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) Non-Small Cell Carcinoma left lung.
DUE TO, OR AS A CONSEQUENCE OF
(c) Chronic Obstructive Pulmonary Disease | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12-18-1986 to 12-7-1986, that (I) (we) lost saw the deceased above, (I) (we) did not see the body after death. | | | | | | | | |
| 22b. SIGNATURE
Dr. Alexander Bogdashevskyi | | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12-7-86 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Dr. Alexander Bogdashevskyi | | | | | | 22e. ADDRESS
3001 S. Hanover Street | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
12-13-86 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Auburn Cemtery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Westport, Baltimore, Md. | |
| 24. FUNERAL DIRECTOR
NAME
Charles A. Rice FSPA 1300 Eutaw Pl, | | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 11 1986 | | 25b. REGISTRAR'S SIGNATURE
Davidson P. ... |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please immediately return pages 1 and 2 to the State Dept. of Health and Mental Hygiene prior to burial, cremation, removal with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|---|--|---|---|-------|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST MIDDLE LAST | | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR | |
| JULIA A. RANDALL | | | | 12-23-86 | | 5:50 PM | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE IN YEARS (LAST BIRTHDAY) | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | |
| Female | White | Sept. 21, 1896 | | 90 YRS. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Maine | USA | | | Baltimore City | | MD. | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Baltimore | John L. Deaton Medical Center | | Homemaker | | Own Home | | |
| 13a. STATE | | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE | | |
| MD | | | Balto. | | 1532 E. Coldspring Lane, | | 21218 |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | |
| Frank M. Small | | Cora Dennison | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| No | | 218 54 3773 | | James H. Keller, | | Same | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Aspiration pneumonia</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Immunized & Deegan Joint Disease</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>S/P Throat & Lip</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (this hospital) attended the deceased from <u>48 hr</u> , 19 <u>86</u> , to <u>23 Dec</u> , 19 <u>86</u> , that (I/we) last saw the deceased alive on <u>23 Dec</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I/we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| <u>J.W. Reed M.D.</u> | | | | | | 12/24/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | |
| J.W. REED M.D. | | 611 S. CHAS. ST. BALTO. MD 21230 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | |
| Cremation | | 12/24/86 | Green Mount | | Balto., MD | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Henry W. Jenkins & Sons Co.
4905 York Road Balto., MD 21212 | | | | DEC 29 1986 | | Julia Davidson-Randall | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reinsert this page into pages 1 and 2 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other condition, the medical examiner must be notified at once.

BP

2018-01-27

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 and file them within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event (i.e., medical negligence), the medical examiner must be notified of this.

BP
DHMH - 16 50M 1/81
(VRA 15, 4)

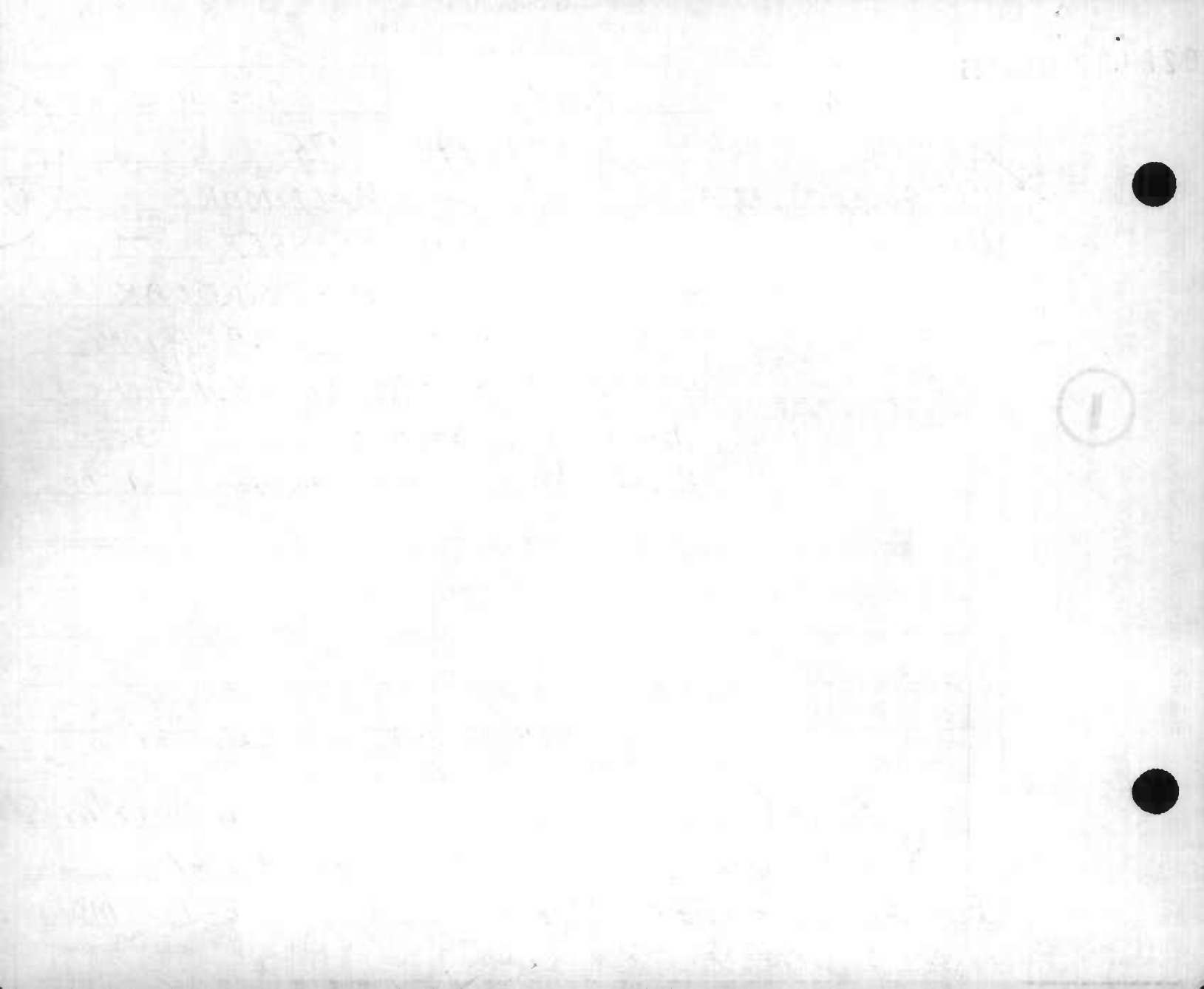
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

| | | | | | | | | | |
|--|--|--|--|---|---|---|--|--|--|
| DECEASED NAME
(TYPE OR PRINT)
Adam Randazzo | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 16 86 | | | 2b. HOUR
8 41 PM | | | |
| 3. SEX
Male | | 4. RACE
white | | 5. DATE OF BIRTH
MONTH DAY YEAR
OCT 14 1911 | | 6. AGE (IN YEARS LAST BIRTHDAY)
75 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7. BIRTHPLACE
(COUNTRY)
ITALY | | 7b. CITIZEN OF WHAT COUNTRY?
ITALY | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
ST AGNES HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
PRESSER | | 12b. KIND OF BUSINESS OR INDUSTRY
— | |
| 13a. STATE
MD | | 13b. COUNTY
BALTO | | 13c. CITY OR TOWN
WESTVIEW | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13. STREET ADDRESS
21228
6118 BURNT OAK RD | |
| 14. FATHER'S NAME
(FIRST MIDDLE LAST)
STEFANO RANDAZZO | | | | 15. MOTHER'S MAIDEN NAME
(FIRST MIDDLE LAST)
ROSA MACAJONE | | | | ADDRESS
6118 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
217-40-0529 | | 17. INFORMANT
CARMELA RANDAZZO BURNT OAK RD | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hypovolemic Shock
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) Ruptured Abdominal Aortic Aneurysm
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
20 min
1 hr | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME STREET FACTORY OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/16, 1986, to 12/16, 1986 that (I) (we) last saw the deceased alive on 12/16, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Robert Udelman | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED
12/16/86 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Robert Udelman MD | | | 22e. ADDRESS
St. Agnes Hospital | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
BURIAL | | | 23b. DATE
12-20-86 | | 23c. NAME OF CEMETERY OR CREMATORY
WOOLPLAWN CEM | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTO MD | | |
| 24. FUNERAL DIRECTOR
NAME
EDWARD J. WEBER F.H. | | | ADDRESS
5311 EDMONDSON AVE. | | 25a. DATE REC'D. BY REGISTRAR
DEC 23 1986 | | 25b. REGISTRAR'S SIGNATURE
Julia Gordon-Rodden | | |

028192 DEC 23 1986



027330 DEC 17 1986

FOR STATE REGISTRAR
12/17/86STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|--|---------|------------------------------------|--|-------------------------------|--------------------------------|--|--|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR | | | 2b. HOUR | | |
| KELLY Louise RANDLE | | | | | | 12-12-86 | | | M | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH
MONTH DAY YEAR | 6. AGE (IN YEARS)
LAST BIRTHDAY YRS. | IF UNDER 1 YR.
MONTHS DAYS | IF UNDER 24 HRS.
HOURS MIN. | 7c. DATE PRONOUNCED DEAD | | | 2d. HOUR | | |
| Female | Black | 10 17 86 | 1 | 24 | | 12-12-86 | | | 6:53a | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Md. | | | USA | | | | | | Baltimore City MD. | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Baltimore | | | Liberty Medical Center | | | | | | | | |
| 13a. STATE | | | 13b. CITY OR TOWN | | | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13d. STREET ADDRESS | | |
| Md. | | | Balto. | | | YES | | | 2544 Madison Avenue | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | | | | | | | |
| Walter Randle | | | Sadie Waters | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | ADDRESS | | |
| | | | | | | Walter Randle Sr. | | | 2544 Madison Ave | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Sudden infant death syndrome</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | TITLE (SPECIFY) | | | | | | DATE SIGNED | | |
| Margarita A. Korell, M.D. | | | M.D. Assistant | | | | | | 12-12-86 | | |
| EXAMINER'S NAME
(TYPE OR PRINT) | | | ADDRESS | | | | | | | | |
| Margarita A. Korell, M.D. | | | 111 Penn Street | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | |
| Burial | | | 12/15/86 | | | Westview Mem. Park | | | Catonsville Md. | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS | | | | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | |
| Chatman-Morris FH 1701 McCulloh St. | | | | | | DEC 15 1986 | | | Julia Davidson-Randall | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM JM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201. PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25MBP
DHMH - 17
(VR A15 ME (5))

SECRET
U.S. GOVERNMENT PRINTING OFFICE
1964 O - 345-000

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5 024 07 02

05L-4

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been completed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | REG. NO. | |
|---|--|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
GERTRUDE RANDOLPH | | | 2a. DATE OF DEATH
MONTH DAY YEAR
DECEMBER 4, 1986 | | 2b. HOUR
11:30 PM | |
| 3. SEX
Female | 4. RACE
Col V | 5. DATE OF BIRTH
MONTH DAY YEAR
5-3-07 | | 6. AGE (IN YEARS LAST BIRTHDAY)
79 YRS | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE JOHNS HOPKINS HOSPITAL | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE Maryland 13b. COUNTY Baltimore 13c. CITY OR TOWN Baltimore | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
1819 Henneman Ave. 21218 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
James Carter | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Jane Harker | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT
ADDRESS
Miss Felicia Coby 2201 Callow Ave. 21217 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hypotensive arrest
DUE TO, OR AS A CONSEQUENCE OF Gastrointestinal
(b) GI bleeding
DUE TO, OR AS A CONSEQUENCE OF
(c) Dissecting aortic aneurysm | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
10 seconds
12/3/86
11/10/86 | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: NO | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED
(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/10 , 19 86 , to 12/4 , 19 86 , that (I) (we) last saw the deceased alive on 12/4 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
Suzanne Koven | | DEGREE
MD | | 22c. DATE SIGNED
12/5/86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
SUZANNE KOVEN MD | | 22e. ADDRESS
Johns Hopkins Hospital | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
12-10-86 | | 23c. NAME OF CEMETERY OR CREMATORY
Baltimore Cem. | | |
| 23d. LOCATION
(CITY OR TOWN) COUNTY STATE
BALTO. Md. | | 23e. DATE REC'D. BY REGISTRAR
DEC 12 1986 | | | | |
| 24. FUNERAL DIRECTOR
NAME
Joseph L. Russ | | ADDRESS
2222 W. North Ave. | | 25. REGISTRAR'S SIGNATURE
John Harker | | |

**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | |
|---|--|---|---|---|
| 1. DECEASED NAME
(PLEASE PRINT)
FIRST MIDDLE LAST
Walter E. Ransom | | 2a. DATE KNOWN OF DEATH
ESTIMATED
MONTH DAY YEAR
12 1 19 86 | | 2b. HOUR
M
6:39P |
| 3. SEX
Male | 4. RACE
Cauc. | 5. DATE OF BIRTH
MONTH DAY YEAR
12 Aug 12 | 6. AGE (IN YEARS)
LAST BIRTHDAY YRS.
74 | 7. IF UNDER 1 YR.
MONTHS DAYS HOURS MIN.
0 0 0 0 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New York | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
3804 Moravia Road | | 12. USUAL OCCUPATION (TYPE OF WORK)
Chief Warrant Officer | 12b. KIND OF BUSINESS OR INDUSTRY
U.S. Army |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | |
| 13a. STATE
Md. | 13b. COUNTY
- | 13c. CITY OR TOWN
Balto. | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
3804 Moravia Rd. 21206 |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Adelbert R. Ransom | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Goldie Fuller | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
081-32-8780 | 17. INFORMANT
ADDRESS
Ronald Ransom, 62 Safran Ave., Edison | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hypertensive cardiovascular disease
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).
Chronic obstructive pulmonary disease | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural cause Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | |
| ACTUAL SIGNATURE
<i>William M. Zane</i> | | TITLE (SPECIFY)
Assistant | | DATE SIGNED
12/3/86 |
| EXAMINER'S NAME
(TYPE OR PRINT)
William M. Zane, M.D. | | ADDRESS
111 Penn St. | | Balto. MD. |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
12/4/86 | 23c. NAME OF CEMETERY OR CREMATORY
Bohemian National | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto. Md. | |
| 24. FUNERAL DIRECTOR
Schimunek Funeral Home, Inc. | | 25. DATE REC'D. BY REGISTRAR
DEC 4 1986 | | |
| 3331 Brehms Lane, Balto., Md. 21213 | | REGISTRAR'S SIGNATURE
<i>John P. ...</i> | | |

MEDICAL CERTIFICATION

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25M

BP
DHMH - 17
(VR A15 ME (5))

050531 180500

93B14-101100.8002

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Jerry

Razor

2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR
12 25 1986 M

3. SEX

male

4. RACE

black

5. DATE OF BIRTH

MONTH DAY YEAR
9 22 1919

6. AGE (IN YEARS LAST BIRTHDAY)

67

IF UNDER 1 YEAR IF UNDER 24 HRS
MONTHS DAYS HOURS MIN.

7a. BIRTHPLACE
(STATE OR FOREIGN
COUNTRY)

N.C.

7b. CITIZEN OF WHAT COUNTRY?

U S A

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore city

MD.

10. CITY OR TOWN OF DEATH

Baltimore

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
5005 Hillen Road

12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)

Retired

12b. KIND OF BUSINESS OR
INDUSTRY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Md

13b. COUNTY

Baltimore

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE

5005 Hillen Road 21239

14. FATHER'S NAME

Henry

MIDDLE

Razor

15. MOTHER'S MAIDEN NAME

Bettie

MIDDLE

Gilliam

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)

Yes

16b. SOCIAL SECURITY NO.

245-18-2030

17. INFORMANT

Luvenia Razor 5005 Hillen Road

ADDRESS

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) CARCINOMA OF PANCREAS

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

8 mos

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☐20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐
AT WORK AT WORK

21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 1986 19 86 to DEC 19 1986, that (I/we) last
saw the deceased alive on DEC 19 1986, and that in (my/our) opinion death occurred on the date and hour and from the causes stated
above, (I/we) (did) (did not) view the body after death.

22b. SIGNATURE

Rh. Lee

DEGREE

ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒

22c. DATE SIGNED

12/30/86

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) Burial

23b. DATE

12/31/86

23c. NAME OF CEMETERY OR CREMATORY

Garrison Forest Vet

23d. LOCATION

CITY OR TOWN COUNTY
Owings Mills

STATE

Md

24. FUNERAL DIRECTOR

NAME

Wm. C. March F/H

ADDRESS

1101 E. North Avenue

25a. DATE REC'D. BY REGISTRAR

JAN 2 1987

25b. REGISTRAR'S SIGNATURE

Julia Davidson-Randall

FOR OFFICIAL USE ONLY



62-346

027271 DEC

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

| | | | | | | | | |
|--|-------------------------|--|---|---|---|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT) DANIEL L. REA | | | 2a. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> MONTH 12 DAY 10 YEAR 1986 | | | 2b. HOUR 5:58 P.M. | | |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH 10 DAY 6 YEAR 1954 | 6. AGE (IN YEARS)
LAST BIRTHDAY 32 YRS. | IF UNDER 1 YR.
MONTHS 0 DAYS 0 | IF UNDER 24 HRS.
HOURS 0 MIN. 0 | 7c. DATE PRONOUNCED DEAD
MONTH 12 DAY 10 YEAR 1986 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
California | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
University Hospital (STU) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Insulator | | 12b. KIND OF BUSINESS OR INDUSTRY
U.S. ARMY |
| 13a. STREET
Ind | | | 13b. COUNTY
Balto | | 13c. CITY OR TOWN
Balto | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST Vernon MIDDLE L. LAST Rea | | | 15. MOTHER'S MAIDEN NAME
FIRST Agnes Irene MIDDLE Knight LAST Rea | | | 16. SOCIAL SECURITY NO.
-1973 | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) Yes | | | 16b. SOCIAL SECURITY NO.
-1973 | | | 17. INFORMANT
Stanley J. Keelert | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Chest injuries
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY
HOUR 4:17 P.M. MONTH 12 DAY 10 YEAR 1986 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
Driver of auto/tractor-trailer collision. | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
road | | 21f. LOCATION
STREET Rt. 170 near Old Telegraph Rd., CITY OR TOWN Anne Arundel, COUNTY MD STATE MD | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accidents <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> | | | | | | | | |
| ACTUAL SIGNATURE
Charles P. Kokes | | | TITLE (SPECIFY)
Assistant | | | DATE SIGNED
12-11-86 | | |
| EXAMINER'S NAME
(TYPE OR PRINT) Charles P. Kokes, M.D. | | | ADDRESS 111 Penn St., Balto., MD 21201 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(TYPE)
Cremation | | | 23b. DATE
12-12-1986 | | 23c. NAME OF CEMETERY OR CREMATORY
Northview Mem. Park | | 23d. LOCATION
CITY OR TOWN Crofton COUNTY Balto STATE MD | |
| 24. FUNERAL DIRECTOR
NAME John J. Brown ADDRESS Balto. Md. 21223 | | | 25a. DATE REC'D. BY REGISTRAR
DEC 15 1986 | | 25b. REGISTRAR'S SIGNATURE
Julia S. S. S. | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. THE MEDICAL EXAMINER ALONG WITH THE REGISTRAR, PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH THE REGISTRAR, PAGE 5 FOR HIS FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGE 4 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP

DHAM - 17
(VITALS ARE 53)

0555



STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

REG. NO.

 1. FOR
 STATE
 REGISTRAR

| | | | | | |
|--|---|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Alice B. Ream | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12/24/86 | | 2b. HOUR
9:39 AM |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
April 30 1892 | | 6. AGE (IN YEARS LAST BIRTHDAY)
94 YRS | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Penna. | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FAC'TY, GIVE STREET ADDRESS)
Liberty Medical Center | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | 12b. KIND OF BUSINESS OR INDUSTRY
Own Home | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md. | | 13b. COUNTY
Balto. | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
5801 Chinquapin Pkwy. 21239 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Orlando Brayshaw | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Crumlick | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No. | | 16b. SOCIAL SECURITY NO.
188-22-4743 | 17. INFORMANT
ADDRESS
Jack H. Ream Balto., Md. | | |

 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
 PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary-Pulm arrest

DUE TO, OR AS A CONSEQUENCE OF

 Conditions, if any, which
 gave rise to immediate
 cause (a), stating the
 underlying cause last.

(b) _____

DUE TO, OR AS A CONSEQUENCE OF

(c) _____

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

| | | | | | |
|---|--|--|--|--|---|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/86</u> , 19 <u>86</u> , to <u>12/24</u> , 19 <u>86</u> , that (s) (we) last saw the deceased alive on <u>12/24</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>T. Ohiokepe, MD</u> | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
12/24/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
T. Ohiokepe, MD | | 22e. ADDRESS
Liberty Medical Center | | | |

| | | | |
|---|-----------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | 23b. DATE
12-26-86 | 23c. NAME OF CEMETERY OR CREMATORY
Greenmount | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto. Md. |
| 24. FUNERAL DIRECTOR
NAME
Henry W. Jenkins & Sons Co., Balto. Md. | | 25a. DATE REC'D. BY REGISTRAR
DEC 29 1986 | 25b. REGISTRAR'S SIGNATURE
Julia Deacon-Richard |



100% COTTON FIBER

100% COTTON FIBER

100% COTTON FIBER

100% COTTON FIBER

027885

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | |
|---|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
WILLIAM T. REDD SR. | | 2a. DATE OF DEATH
MONTH 12 DAY 18 YEAR 86 | | 2b. HOUR
7:31A |
| 3. SEX
MALE | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH 10 DAY 04 YEAR 1924 | | 6. AGE (IN YEARS LAST BIRTHDAY)
62 YRS. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
St. Agnes Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Oil Burner Mech | 12b. KIND OF BUSINESS OR INDUSTRY
lumber company |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE Md. 13b. COUNTY Howard | | 13c. CITY OR TOWN
Elkridge | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST William MIDDLE R. LAST Redd | | 15. MOTHER'S MAIDEN NAME
FIRST Mary MIDDLE L. LAST Roberts | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WW II | 17. INFORMANT
ADDRESS Balto., Md. 21227
William T. Redd Jr. 6414 Woodburn Ave. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Septic shock
DUE TO, OR AS A CONSEQUENCE OF
(b) Pneumonia
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)
COPD | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET | CITY OR TOWN | COUNTY STATE |
| 22a. I certify that (I) (this hospital) attended the deceased from Dec 1 , 19 86 , to Dec 18 , 19 86 , that (I) (we) last saw the deceased alive on Dec 18 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | |
| 22b. SIGNATURE
Gonzalo F. Urbano | DEGREE
M.D. | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED
12/18/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Gonzalo F. Urbano | | 22e. ADDRESS
St. Agnes Hospital | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
burial | 23b. DATE
12/22/86 | 23c. NAME OF CEMETERY OR CREMATORY
Ivy Hill Cemetery | 23d. LOCATION
CITY OR TOWN
Laurel | COUNTY STATE
Prince Georges Md. |
| 24. FUNERAL DIRECTOR
NAME
Gary L. Kaufman | | ADDRESS
5695 Main St., Elkridge, Md 21227 | 25a. DATE REC'D. BY REGISTRAR
DEC 22 1986 | 25b. REGISTRAR'S SIGNATURE
Julia Davidson |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be required by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please return to the State Dept. of Health and Mental Hygiene. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "yes," item 18 shows only injury, or other traumatic event, the medical examiner must be notified.

4

027907 DEC 22 1986

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 3 4 8 7 1

| FOR STATE REGISTRAR | | | | REG. NO. | | | |
|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
ESTHER BELLE REESE | | | | 2a. DATE OF DEATH MONTH DAY YEAR
12/15/86 | | 2b. HOUR
8:30P.M. | |
| 3. SEX
FEMALE | | 4. RACE
W | | 5. DATE OF BIRTH MONTH DAY YEAR
11/17/25 | | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.
61 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
ST. AGNES HOSPITAL | | 12a. USUAL OCCUPATION (WORK OR OTHER WORKING LIFE)
PUNCH PRESS OPERATOR | | 12b. KIND OF BUSINESS OR INDUSTRY
DIE & TOOL | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MARYLAND | | | | 13b. CITY OR TOWN
BALTIMORE | | 13c. STREET ADDRESS / ZIP CODE
7125 ROLLING BEND RD. 21207 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
CARROLL REESE | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
BERTHA GATRELL | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
216-22-7936 | | 17. INFORMANT ADDRESS
CHESTER REESE 4111 KLAUSMIER RD. BALTIMORE, Md | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Intracerebral hemorrhage
DUE TO, OR AS A CONSEQUENCE OF (b) Hypertension
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
12/13 19 86 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/13 19 86 to 12/15 19 86 that I (we) last saw the deceased alive on 12/15 19 86 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
William L. Hicken MD | | DEGREE
MD | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
12/16/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
W. L. HICKEN, M.D. | | 22e. ADDRESS
900 CATON AVE. BALTIMORE, MD. 21229 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
12/19/86 | | 23c. NAME OF CEMETERY OR CREMATORY
LINGANORE CEMETERY | | 23d. LOCATION CITY OR TOWN COUNTY STATE
UNIONVILLE FREDERICK MD | |
| 24. FUNERAL DIRECTOR NAME
D. D. HARTZLER | | | | ADDRESS
UNION BRIDGE, MD | | 25a. DATE REC'D. BY REGISTRAR
DEC 22 1986 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed by the attending physician, and the body be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 3 4 8 7 2

1 - FOR
STATE
REGISTRAR

REG. NO.

ERROR

| | | | | | | | | |
|--|---|---|--|--|---|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| FIRST MIDDLE LAST
CHARLES L. REIS | | | MONTH DAY YEAR
12/18/86 8/22/86 | | | 4:20 PM | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. UNDER 1 YEAR | | 8. UNDER 24 HRS. |
| MALE | White | MONTH DAY YEAR
8 22 31 | | 65 YRS | | MONTHS DAYS HOURS MIN. | | |
| 9a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY) | 9b. CITIZEN OF WHAT COUNTRY? | 9c. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | |
| MARYLAND | U.S.A. | | | BALTIMORE CITY MD. | | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| BALTIMORE | GOOD SAMARITAN HOSPITAL | | | REHAB. COUNS | | MARYLAND | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | 13b. INSIDE CITY LIMITS? | | 13c. STREET ADDRESS / ZIP CODE | | | |
| 13a. STATE COUNTY CITY OR TOWN
MARYLAND BALTIMORE PARKVILLE | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 8719 MARAVOSS LANE 21234 | | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | |
| FIRST MIDDLE LAST
GEORGE H. REIS | | | FIRST MIDDLE LAST
MARY W. MARTENS | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO | | 17. INFORMANT | | | |
| YES | | | W-W-II 215127043 | | FAMILY RECORDS | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) SHOCK
DUE TO, OR AS A CONSEQUENCE OF (b) PNEUMONIA - Pleural Effusion
DUE TO, OR AS A CONSEQUENCE OF (c) PARKINSON'S DISEASE - Oligo pontine Dematula | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED
(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/18, 1986, to 12/18, 1986, that (I) (we) last saw the deceased alive on 12/18, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE | | | DEGREE | | | 22c. DATE SIGNED | | |
| Michael Chait | | | | | | 12/18/86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22e. ADDRESS | | | | | |
| Michael Chait | | | GOOD SAMARITAN, 5601 Loch Raven | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | |
| BURIAL | | | 12-20-1986 | | PARKWOOD LEM. | | PARKVILLE BALTO. MD. | |
| 24. FUNERAL DIRECTOR
NAME | | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| EVANS CHAPL OF MEMORIES ROAD | | | 8800 HARFORD | | DEC 19 1986 | | John Gordon Hughes | |

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|
| 027164 DEC 15 86 | | | | | | | | | | STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 8 6 3 4 8 7 3 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1- STATE REGISTRAR | | | | | | | | | | REG. NO. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
MARRY Mamie-Mary Rennie | | | | | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
12 10 86 | | | | | | | | | | 2b. HOUR
9A M | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. SEX
Female | | | | | | | | | | 4. RACE
white | | | | | | | | | | 5. DATE OF BIRTH MONTH DAY YEAR
09 16 89 | | | | | | | | | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS HOURS MIN.
97 | | | | | | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Baltimore, Md | | | | | | | | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | | | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | | | | | | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
John L. Deaton Hospital & Med. Cent. | | | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | |
| 13a. STATE
MARYLAND | | | | | | | | | | 13b. COUNTY
BALT | | | | | | | | | | 13c. CITY OR TOWN
Baltimore | | | | | | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | 13e. STREET ADDRESS / ZIP CODE
1504 Webster St. Baltimore, Md. 21230 | | | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
MARTIN JOHN --- MARTIN | | | | | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Sarah --- Gerberick | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
NO | | | | | | | | | | 16b. SOCIAL SECURITY NO.
220-48-9545 | | | | | | | | | | 17. INFORMANT ADDRESS
Mr. Norman J. Rennie, Sameas Above | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) - Cardiorespiratory Arrest. DUE TO, OR AS A CONSEQUENCE OF (b) - Cerebrovascular Accident. DUE TO, OR AS A CONSEQUENCE OF (c) - | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | | | | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | | | | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from December 8, 1985 to December 10, 1986, that (I) (we) last saw the deceased alive on December 9, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
RUBEN REIDER M.D. | | | | | | | | | | DEGREE | | | | | | | | | | 22c. DATE SIGNED
12/10/86 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | | | | | 22e. ADDRESS
7445 A FURNACE BRANCH RD | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | | | | | | | 23b. DATE
12/13/86 | | | | | | | | | | 23c. NAME OF CEMETERY OR CREMATORY
Lorraine Park Cent. | | | | | | | | | | 23d. LOCATION CITY OR TOWN COUNTY
Baltimore, Md. BALTO. Co. Md. | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME
McCuilly Funeral Home, 130 E. Fort Ave. | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 12 1986 | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE
Julia Pender-Randall | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of case.

BP

DHMH - 16 60M 7/B4 (VRA 15, 4)

051154 151150

2026 COTTON JERSEY

CHIEF W. DOW

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

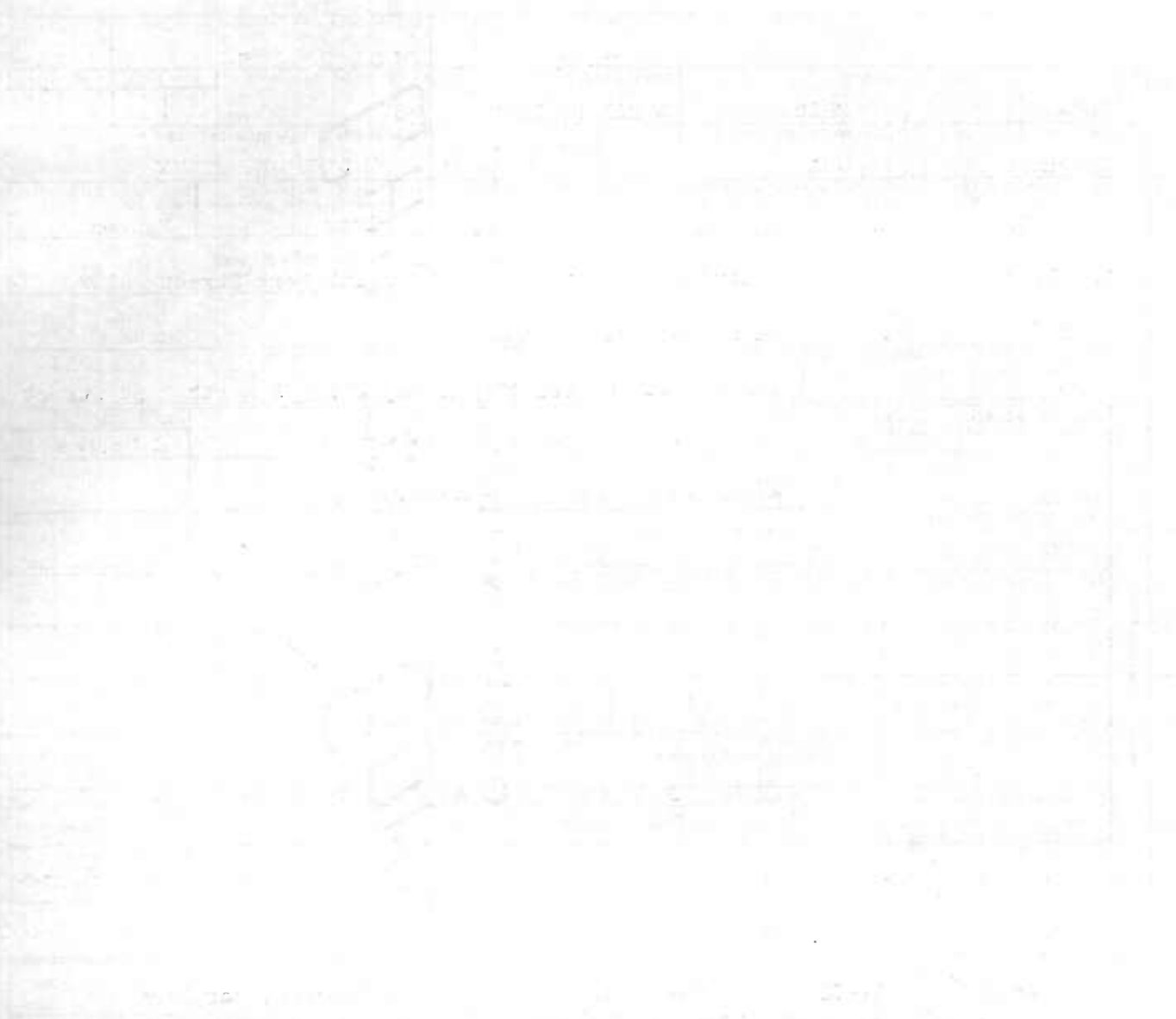
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the top flap. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic incident, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | | | | | |
|---|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
FRED REYNOLDS | | | | 2a. DATE OF DEATH MONTH DAY YEAR
DEC. 28, 1986 | | | | 2b. HOUR
2:10AM | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
April 9, 1929 | | 6. AGE (IN YEARS LAST BIRTHDAY)
57 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Kentucky | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
JOHNS HOPKINS HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Driver | | 12b. KIND OF BUSINESS OR INDUSTRY
Rentex | |
| 13a. STATE
Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
8 North Port Street 21224 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Fred J. Reynolds, Sr. | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Kate Mays | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
405-34-6752 | | 17. INFORMANT
ADDRESS
Dorothy L. Reynolds 8 North Port Street 21224 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST
DUE TO, OR AS A CONSEQUENCE OF
(b) MYOCARDIAL INFARCTION
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 hours | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from DEC 27 , 19 86 , to DEC 28 , 19 86 , that (I) (we) lost saw the deceased alive on DEC 28 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Julie Z Livingston | | | | DEGREE
MD
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED
12/28/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Julie Z Livingston | | | | 22e. ADDRESS
600 N. Wolfe St Balto, MD 21205 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
12-31-86 | | 23c. NAME OF CEMETERY OR CREMATORY
Oak Lawn | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Maryland | | | |
| 24. FUNERAL DIRECTOR
NAME
Duda-Ruck Funeral Home of Dundalk
7922 Wise Ave. ADDRESS
Dundalk, MD 21222 | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 29 1986 | | 25b. REGISTRAR'S SIGNATURE
Julie Z Livingston | | | |

RESEARCH REPORT



1

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

| | | | | | |
|---|--|--|---|--|---|
| 2a. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
VICTORIA JANE RHINE | | | 2b. DATE OF DEATH
MONTH DAY YEAR HOUR
12 11 86 2:55 PM | | |
| 3 SEX
Female | 4 RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
August 14, 1945 | 6. AGE (IN YEARS LAST BIRTHDAY)
41 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNION MEMORIAL HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | |
| 13a. STATE
Maryland | 13b. COUNTY | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
604 E. 35th St. 21218 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Gustav William Koors | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Edna Elizabeth Ritchie | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
218-40-9801 | | 17 INFORMANT
ADDRESS
Rhona Bowen 1800 Wendover Rd.
Baltimore, Md. 21234 | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Acute Anterolateral Myocardial Infarction</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Occlusion of the Left Coronary Artery</u>
CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
8 hrs. |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0 | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 11th</u> , 19 <u>86</u> , to <u>Dec 11th</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>Dec 11th</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>J. Raduatto</u> | | DEGREE
MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
12-11-86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Joseph L. Raduatto MD | | 22e. ADDRESS
201 E. Univ. Pkwy Box #3 Balt. MD 21218 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Dec. 13, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY
Dulaney Valley Mem. | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Timonium, Baltimore Co., Md. | | | | | |
| 24 FUNERAL DIRECTOR
NAME
Mitchell-Wiedefeld Home, Inc. Balto., Md. 21212 | | ADDRESS
6500 York Rd. | | 25a. DATE RECEIVED BY REGISTRAR
DEC 13 1986 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

02/30/1931

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3186 FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--------------------------------|--|--------------------------------|--|--|--|------|--|----------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 20. DATE OF DEATH | | MONTH | | DAY | | YEAR | | 2b. HOUR | |
| ROSA | | (LEE) | | RHINEHART | | | | DECEMBER 17, 1986 | | | | | | | | 12:56A | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | | | | | | |
| FEMALE | | BLACK | | MONTH DAY YEAR
9 30 30 | | 56 YRS. | | MONTHS DAYS | | HOURS MIN. | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | |
| S.C. | | USA | | | | BALTIMORE CITY | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | |
| BALTIMORE | | THE JOHNS HOPKINS HOSPITAL | | DISABLED | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. STATE | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS / ZIP CODE | | | | | | | | | |
| MD | | BALTO. | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 1231 N. BOND ST. 21213 | | | | | | | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | |
| WADE | | HOLLIS | | OLEA | | BROWN | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | | 17. INFORMANT | | ADDRESS | | | | | | | | | | | |
| NO | | 216628259 | | LOUISE GRAY | | 1231 N. BOND STREET 21213 | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | PART 1. DEATH WAS CAUSED BY: | | IMMEDIATE CAUSE (a) | | DUE TO, OR AS A CONSEQUENCE OF | | DUE TO, OR AS A CONSEQUENCE OF | | DUE TO, OR AS A CONSEQUENCE OF | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| | | | | Cardiopulmonary arrest | | Cardiomyopathy, hyperkalemia | | Coronary artery disease | | | | 10 min | | | | | |
| | | | | | | | | | | | | 4 yrs | | | | | |
| | | | | | | | | | | | | 6 yrs | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | | | | |
| | | HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY | | 21f. LOCATION | | | | | | | | | | | | | |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | [AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.] | | STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from December 14, 1986, to December 17, 1986, that (I) (we) lost | | 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | | | | | | | | | | | |
| saw the deceased alive on December 17, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | Susan M. Melley | | MD | | 12/17/86 | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | | | | | | | | | |
| Melley | | The Johns Hopkins Hospital | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | | | | | | | | | |
| BURIAL | | 12-21-86 | | EASTVIEW CEMETERY | | BALTO., MD | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | |
| MARCH FUNERAL HOME 1101 E. NORTH AVE. | | DEC 19 1986 | | John A. Anderson | | | | | | | | | | | | | |

2000

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58 FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|---|---------|---|--|---|--|--|--------------------------------------|---|-----------------------------|----------|---|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | | MONTH | DAY | YEAR | 2b. HOUR | |
| EARL E. RICH | | EARL | E. | RICH | 12 06 86 | | | | | 11 55 AM | |
| 3. SEX | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | |
| M | B | | 4/2/13 | | 73 | | MONTHS | | DAYS | | MIN. |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| BALTIMORE | | US | | | | CITY (BALTIMORE) MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| BALTIMORE | | BALTIMORE VA HOSPITAL | | | | Retired | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS / ZIP CODE | | | | |
| 13a. STATE
MD | | | | | 13d. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. 1702 PAYSON ST 21217 | | | | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| FIRST MIDDLE LAST
James Taylor | | | | | FIRST MIDDLE LAST
Bertha Gordon | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | |
| YES | | | | | 5/43 1/46 217-05 4243 | | Geneva Rich 1702 N. Payson St. 21217 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>SQUAMOUS CELL CARCINOMA OF LUNG</u>
PART 2. OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a.
<u>HYPERCALCEMIA SQUAMOUS CELL CANCER OF LUNG</u> | | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/29</u> , 19 <u>86</u> , to <u>12/6</u> , 19 <u>86</u> , that (I) (we) lost
saw the deceased alive on <u>12/6</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>P. Becker</u> | | | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED
12/6/86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
P. BECKER | | | | | | 22e. ADDRESS
BALTIMORE VA HOSPITAL | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | | |
| Burial | | | 12/11/86 | | Md. Veteran Cem. | | Crownsville A.A. Md. | | | | |
| 24. FUNERAL DIRECTOR
NAME Chas. A. Rice FSPA 1300 Eutaw Place ADDRESS | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
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MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the topographical pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



027950 DEC 23

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | |
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| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH | | XX MONTH DAY YEAR | | 2b. HOUR | |
| LILLIAN | | RICHARDSON | | | | | | ESTIMATED <input type="checkbox"/> 11-27-86 | | | | M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD | | 2d. HOUR | |
| Female | Black | 09 | | 77 YRS. | | | | | | 11-27-86 | | 6:45 PM | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | |
| Virginia | | U.S. | | | | Baltimore City | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| Baltimore | | Liberty Medical Center | | (Social Services) | | | | | | | | | |
| 13a. STATE | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | |
| Md. | | | | | | Balto. | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | 4136 Reisterstown Rd. | | 21215 | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | |
| FIRST MIDDLE LAST | | | | FIRST MIDDLE LAST | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | |
| No | | | | 216-78-2829 | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: | | | | | | | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a. | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | | | | | |
| | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| | | | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | |
| | | | | P.M. 19 | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION | | | | | |
| | | | | | | | | STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | TITLE (SPECIFY) | | | | DATE SIGNED | | | | | |
| Margarita A. Korell, M.D. | | | | Assistant | | | | 11-28-86 | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS | | | | | | | | | |
| | | | | 111 Penn Street | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | |
| Removal | | | | 12-9-86 | | | | | | | | | |
| 23d. LOCATION | | | | CITY OR TOWN | | | | COUNTY STATE | | | | | |
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| 24. FUNERAL DIRECTOR | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| NAME ADDRESS | | | | DEC 11 1986 | | | | Julia Davidson-Randall | | | | | |
| Anatomy Board | | | | Balto., Md. | | | | | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGE NO. AND J TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FOR RECORDS. PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

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FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

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| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2b. DATE KNOWN OF DEATH | | <input checked="" type="checkbox"/> MONTH | | DAY | | YEAR | | 2b. HOUR | | | | | |
| Donnell | | | | | | Ringgold | | 12/ 27/ 1986 | | | | | | | | M | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | MONTH | | DAY | | YEAR | | 2d. HOUR | |
| MALE | | BLACK | | 05-23-47 | | 39 | | YRS. | | | | 12/ 27/ 1986 | | | | | | | | P M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | | | | MD. | |
| BALTO., MD. | | USA | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | Baltimore City, | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | |
| Baltimore | | 6226 Fortview | | | | | | | | | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | | | | | | | | | |
| MARYLAND | | | | BALTIMORE | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 6226 Fortview Way | | | | | | | | | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | | | | |
| LEROY | | RINGGOLD | | MAE FRANCES EBROW | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | | | | | | | | | |
| YES | | 219-50-0551 | | MAE FRANCES RINGGOLD | | 145 HENRIETTA | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | PART I DEATH WAS CAUSED BY: | | IMMEDIATE CAUSE (a) | | Gastrointestinal Hemorrhage & Cirrhosis of Liver | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | |
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REC-30 1000

029404 JAN 6 1987

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 10. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/B4
25M
 BP _____
 DHMH - 17
 (VR A15 ME (S))

 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | | | | |
|--|--------|---|--|--|--|---|--|--|--|--------------------------|--|-------|--|------|--|----------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH | | MONTH | | DAY | | YEAR | | 2b. HOUR | |
| LORRAINE | | | | | | ROANE | | X | | 12 | | 29 | | 1986 | | M | |
| 3 SEX | 4 RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | MONTH | | DAY | | YEAR | |
| Female | Black | 7 29 47 | | 39 YRS | | | | | | 12 | | 29 | | 1986 | | 5:15 AM | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | |
| Baltimore | | USA | | | | Baltimore City | | | | | | | | | | MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | |
| Baltimore | | 1617 Moreland Ave. | | UnEmployed | | | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | | | | | |
| Maryland | | | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 1617 Moreland Ave. | | | | | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | |
| Theodore | | Brogdon | | Climmie | | Sumter | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | | | | | |
| No | | 218-44-3891 | | Geraldine Miller | | 1014 N. Warwick Ave. | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | PART I DEATH WAS CAUSED BY: | | IMMEDIATE CAUSE (a) Peritonitis | | DUE TO, OR AS A CONSEQUENCE OF | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| | | | | (b) Pelvic inflammatory disease | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| | | | | (c) | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2) | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | TITLE (SPECIFY) | | M.D. Assistant | | MEDICAL EXAMINER | | DATE SIGNED | | 12-29-86 | | | | | | | |
| ACTUAL SIGNATURE | | EXAMINER'S NAME (TYPE OR PRINT) | | William M. Zane, M.D. | | ADDRESS | | 111 Penn St., Balto., MD | | 21201 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| Burial | | 1/3/87 | | King Memorial Cem. | | Randlestown | | Md. | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | |
| W.C. March F.H. 4300 Wabash Ave. | | JAN 5 1987 | | Julia Seiden-Pendall | | | | | | | | | | | | | |

MEDICAL CERTIFICATION

0500000000

1

JAN 2 1987

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon copies of Pages 1 and 2 and be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | REG. NO. | | |
|--|--|---|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Charles William Robb | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 12 21 86 | | |
| 3. SEX Male | | | | | 2b. HOUR 11:30 A.M. | | |
| 4. RACE Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR 02 17 1922 | | 6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | |
| 9. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mercy | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer | | 12b. KIND OF BUSINESS OR INDUSTRY Engineer Local | | 37 | | | |
| 13a. STATE Maryland | | 13b. CITY OR TOWN Westminster | | 13c. STREET ADDRESS / ZIP CODE 725 Frizzellburg Rd 21157 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Charles William Robb | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Daisy Belle Dembeck | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes (IF YES, GIVE WAR OR DATES) W W II | | | |
| 16b. SOCIAL SECURITY NO. 215-145818 | | 17. INFORMANT Aileen M. Robb | | ADDRESS 725 Frizzellburg Rd. Westminster, MD. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiopulmonary ARREST
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastatic Bronchogenic Ca
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10 | | | | | | | |
| 19a. DATE OF OPERATION Cystoscopy / Excision | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Urinary Retention | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12-17 , 19 86 , to 12-21 , 19 86 , that (I) (we) lost saw the deceased alive on 12/21 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Valerie L. Moore MD. | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 12/21/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Valerie L. Moore MD | | | | 22e. ADDRESS 301 St. Paul Place Baltimore Md 21202 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 12/24/86 | | 23c. NAME OF CEMETERY OR CREMATORY Pipe Creek Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE nr. New Windsor Carroll MD | |
| 24. FUNERAL DIRECTOR NAME D. D. Hartzler | | | | ADDRESS New Windsor, MD | | 25a. DATE REC'D. BY REGISTRAR Dec 23 1986 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall | |

BP _____

02517-100000

1

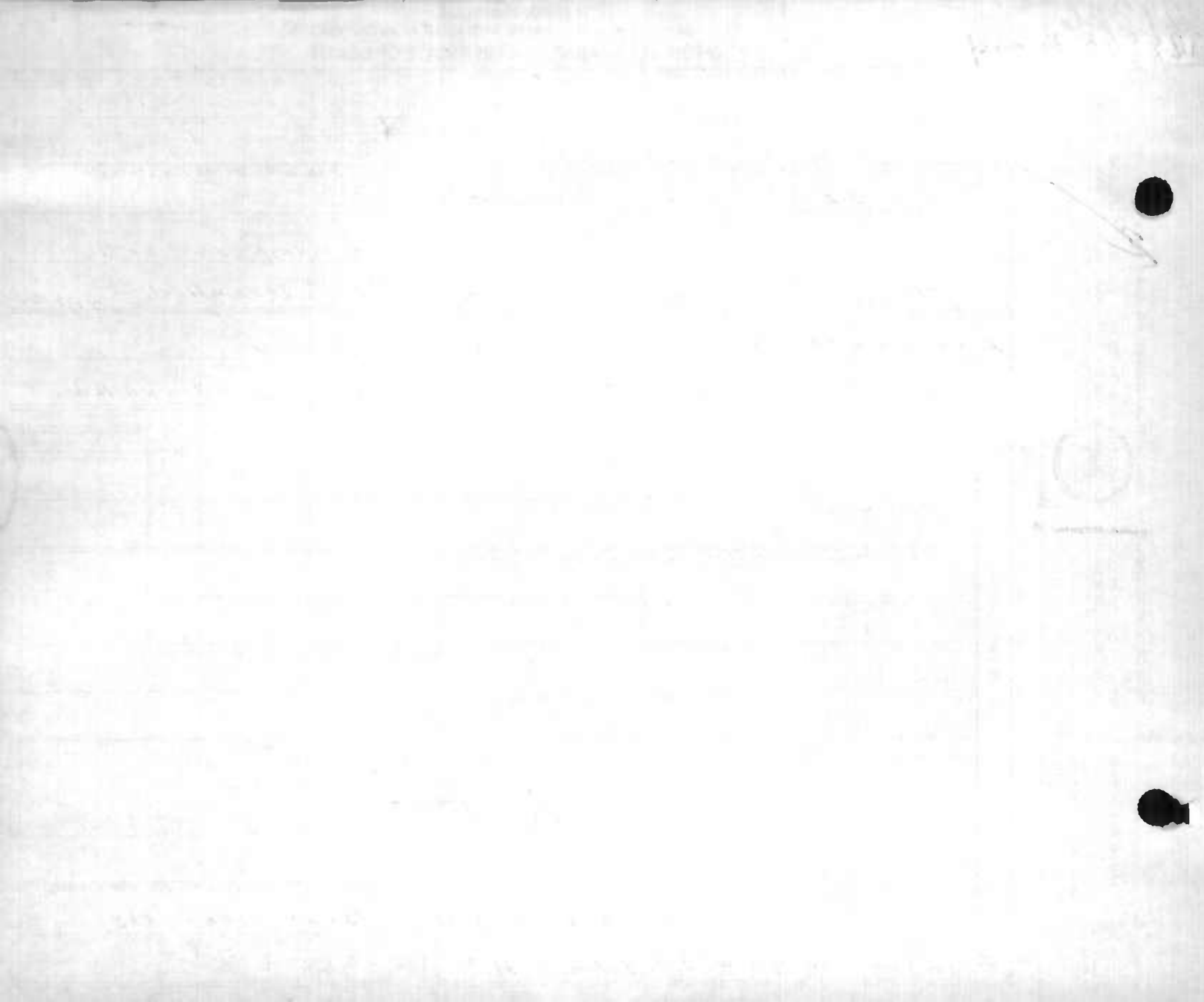
MEDICAL CERTIFICATION

BP_____

DHMH - 17

(VR A15 ME (5))

DHMH - 17
(VR A15 ME (5))



027517 DEC 18 1986

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 3 4 8 8 5

REG. NO.

| | | | | | | | |
|--|--|--|--|---|---------------------------------------|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Doc Roberts Jr. | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 10 86 | | | 2b. HOUR
4:10 A | |
| 3. SEX
male | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
07 09 1927 | | 6. AGE (IN YEARS LAST BIRTHDAY)
59 YRS. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
USA | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Loch Raven Veterans Administration | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
custodian | |
| 12b. KIND OF BUSINESS OR INDUSTRY
City | | | | | | | |
| 13a. STATE
Maryland | | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Doc Roberts | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mamie Miller | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
Yes-3-7-46 | | 17. INFORMANT
Bertha A. Roberts | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) cardiorespiratory arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) seizure
DUE TO, OR AS A CONSEQUENCE OF
(c) alcohol abuse | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 minute
33 days | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
infection | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11-8 , 19 86 , to 12-10 , 19 86 , that (I) (we) lost saw the deceased alive on 12-10 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Michele Gaier | | DEGREE
MD | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
12-10-86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Michele Gaier | | 22e. ADDRESS
Loch Raven VA med center | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
12-15-86 | | 23c. NAME OF CEMETERY OR CREMATORY
G.F.V.A. Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
OWINGS MILLS MD | |
| 24. FUNERAL DIRECTOR
NAME
Randolph J. Cullick | | ADDRESS
2436 Oliver St. | | 25. DATE REC'D. BY REGISTRAR
DEC 16 1986 | | 25. REGISTRAR'S SIGNATURE
Julia Benson-Randall | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the official physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with various other death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

| | | | | | |
|--|--|---|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
LEILA B. ROBERTS | | | 2a. DATE OF DEATH
MONTH DAY YEAR
DECEMBER 1, 1986 | | 2b. HOUR
M |
| 3. SEX
Female | 4. RACE
Black | 5. DATE OF BIRTH
MONTH DAY YEAR
1 8 23 | | 6. AGE (IN YEARS LAST BIRTHDAY)
63 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY, MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
535 ROSSITER AVENUE | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
N/A | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | 13b. COUNTY | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Charles E. Brown | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Pearl Kess Brown | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
219-18-1191 | | 17. INFORMANT
ADDRESS
Brenda Roberts Brown 3530 White Chapel Rd. | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Metastatic Cancer

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

18 yrs

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b)

Carcinoid tumor of bowel

DUE TO, OR AS A CONSEQUENCE OF

(c)

10 years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

| | | | |
|---|---|--|---|
| 19a. DATE OF OPERATION
20/16/86 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Basaloid outlet obstruction | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost
saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
Michael Zindler | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED
12/3/86 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Michael Zindler | | 22e. ADDRESS
Johns Hopkins | |

| | | | |
|--|----------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | 23b. DATE
12/6/86 | 23c. NAME OF CEMETERY OR CREMATORY
Arbutus Memorial Pk. | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Arbutus, Md. |
| 24. FUNERAL DIRECTOR
NAME
March Funeral Homes | | 25a. DATE RECD. BY REGISTRAR
DEC 5 1986 | |
| ADDRESS
1101 East North Avenue | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

NO. 2 COL: 41

10-03

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10-03

10-03

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Theodore - Roberts | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 18 '86 | | | |
| 3. SEX
Male | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
11 03 1906 | | 6. AGE (IN YEARS LAST BIRTHDAY)
80 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Accomac, VA | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
1520 Moreland Ave. 21217 | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
unemployed. | | 12b. KIND OF BUSINESS OR INDUSTRY
- | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 13a. STATE
MD | | 13b. COUNTY
- | | 13c. CITY OR TOWN
Baltimore | | 13e. STREET ADDRESS / ZIP CODE
1520 Moreland Ave. 21217 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Theodore - Roberts | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Letitia Savage | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | 16b. SOCIAL SECURITY NO.
220-03-8902 | | 17. INFORMANT ADDRESS
Amanda Roberts-1520 Moreland Ave. Balto., Maryland | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Cardiac arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) Met. CA Prostate, widespread mets.
DUE TO, OR AS A CONSEQUENCE OF
(c) Malnutrition, Syncope
Approximate interval between onset and death: 2 yrs., 1984 | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) this hospital attended the deceased from 11/17/86, 1986, to 12/18, 1986, that I/we last saw the deceased alive on 12/16, 1986, and that in my/our opinion death occurred on the date and hour and from the causes stated above, (1) we/they did/did not view the body after death. | | | | | | | |
| 22b. SIGNATURE
Mohamed S. Al-Ibrahim M.D. | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
Dec 19, 1986 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Mohamed S. Al-Ibrahim, M.D. | | | | 22e. ADDRESS
861 Park Ave., Balto., MD 21201 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
12-23-86 | | 23c. NAME OF CEMETERY OR CREMATORY
Accomac | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Accomac- Accomack, Va. | |
| 24. FUNERAL DIRECTOR
NAME
Keith E. H. Wharton - Accomack, Va. 23301 | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 29 1986 | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE
Julia Swinton-Badger | | | |

Handwritten notes and diagrams on lined paper. The text is mostly illegible due to fading and bleed-through. A circled number '1' is visible on the right side. At the bottom, there is a printed number '303 22232'.

026427 DEC


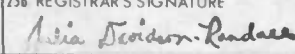
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 1 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M
 BP
DHMH - 17
(VR A15 ME (5))

 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | |
|--|---------|---|--|--|--|--|--|--|--|--|--|------------------|
| 1- FOR STATE REGISTRAR | | 20. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 12 2 19 86 | | | | | | | | | | 21. HOUR M 8:55A |
| 3- DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | | | | | |
| Annette ROSALIE Robinson | | | | | | | | | | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS | | IF UNDER 1 YR. MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR | | 2d. HOUR M |
| FEMALE | WHITE | MAY 28, 1940 | | 46 | | | | | | 12 2 19 86 | | |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7c. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | |
| MARYLAND | | U.S.A. | | | | Baltimore City MD | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| Baltimore | | University Hospital | | | | OFFICE MANAGER | | INSURANCE OFFICE | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS | | | | |
| MARYLAND | | BALTIMORE | | BALTIMORE | | | | 6953 BLANCHE RD. 21215 | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | | | |
| UNKNOWN | | | | EVA SHAPIRO | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | | |
| | | | | | | MR. BRIAN ROBINSON 6953 BLANCHE RD. 21215 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | | | |
| 8151 IMMEDIATE CAUSE (a) Multiple injuries | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. | | | | | | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR XX MONTH DAY YEAR 6:30 P.M. 12 1 1986 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | |
| | | | | | | Passenger in auto/fixed object impact | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE Rt. 695 (exit 9) Baltimore MD | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | |
| ACTUAL SIGNATURE  | | | | TITLE (SPECIFY) M.D. Assistant | | | | DATE SIGNED 12/2/86 | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) William M. Zane, M.D. | | | | ADDRESS 111 Penn St. Balto. MD. | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 12/3/86 | | 23c. NAME OF CEMETERY OR CREMATORY ANSHE EMUNAH CEMETERY | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND | | | | |
| 24. FUNERAL DIRECTOR'S NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD. BALTIMORE, MD 21215 | | | | | | 25a. DATE REC'D. BY REGISTRAR DEC 5 1986 | | 25b. REGISTRAR'S SIGNATURE  | | | | |

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | |
|---|--|---|--|---|---|--|---|---|--|--|
| DECEASED NAME
(TYPE OR PRINT)
Cordelia Robinson | | | 2a. DATE OF DEATH MONTH DAY YEAR
12 24 86 | | | 2b. HOUR
3 30 A M | | | | |
| 1. SEX
F | | 4. RACE
B | | 5. DATE OF BIRTH
MONTH DAY YEAR
7 20 02 | | 6. AGE (IN YEARS LAST BIRTHDAY)
84 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(If not in such facility, give street address)
Liberty Medical Center | | | | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE)
Disabled | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| USUAL RESIDENCE (If nursing home or other institution, give residence before admission)
14a. STATE
MD | | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Unkn | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Unkn | | | 13e. STREET ADDRESS / ZIP CODE
2914 Oakford Ave 21215 | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO.
(If yes, give war or dates)
154-01-0304 | | 17. INFORMANT ADDRESS
Mary Larkin 2914 Oakford Ave | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PNEUMONIA | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | DUE TO, OR AS A CONSEQUENCE OF (b) DEHYDRATION | | | | | | | |
| | | | DUE TO, OR AS A CONSEQUENCE OF (c) HYPOTENSION | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a
CVA, HYPERTENSION, CHF | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in item 18, Part I or Part 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(At home, street, factory, office, farm, etc.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/23/86 to 12/24/86, that (I) (we) last saw the deceased alive on 12/24/86 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
C. Woreta, MD | | | DEGREE | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12/24/86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
AMBROSE WORETA | | | 22e. ADDRESS
Liberty Medical Center | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
12/27/86 | | 23c. NAME OF CEMETERY OR CREMATORY
Eastview Mem. Pk. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Dundalk, Md. | | | |
| 24. FUNERAL DIRECTOR
NAME
Wm C March F/H West | | | | | ADDRESS
4300 Wabash Ave. | | 25a. DATE REC'D. BY REGISTRAR
DEC 30 1986 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | |

028817 JAN - 1986

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) REV. MARY I. ROBINSON | | | 2a. DATE OF DEATH
MONTH 12 DAY 21 YEAR 86 | | | 2b. HOUR
M | |
| 3. SEX
FEMALE | | 4. RACE
BLACK | | 5. DATE OF BIRTH
MONTH 6 DAY 8 YEAR 1926 | | 6. AGE (IN YEARS LAST BIRTHDAY)
60 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE City MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
LIBERTY MEDICAL CENTER | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
NURSE (RETIRED) | |
| 12b. KIND OF BUSINESS OR INDUSTRY | | 13a. STATE
MARYLAND | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
BALTIMORE | |
| 14. FATHER'S NAME
FIRST JOHN MIDDLE LAST TURNER | | 15. MOTHER'S MAIDEN NAME
FIRST ETHEL MIDDLE LAST HAMPTON | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO | | 17. SOCIAL SECURITY NO.
212-34-4351 | |
| 18a. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
(IMMEDIATE CAUSE (a))
Cardiopulmonary Arrest
DUE TO, OR AS A CONSEQUENCE OF:
(b)
Coronary Artery Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
Primary Hypertension - Diabetes mellitus
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):
Peripheral Vascular Disease | | 18b. DATE OF OPERATION | | 18c. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 18d. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 19a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20a. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 20b. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18b PART 1 OR PART 2) | | 20c. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21b. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21c. LOCATION
STREET CITY OR TOWN COUNTY STATE | | 21d. I certify that (I) (this hospital) attended the deceased from above, (I) (we) (did) (did not) view the body after death. | |
| 22a. SIGNATURE
Robert J. Williams | | 22b. DEGREE
MD | | 22c. ADDRESS
4605 ED MONOD AVE BALLO MOET | | 22d. DATE SIGNED
12/23/86 | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) BURIAL | | 23b. DATE
12-29-1986 | | 23c. NAME OF CEMETERY OR CREMATORY
CEDAR HILL CEMETERY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE MARYLAND | |
| 24. FUNERAL DIRECTOR
NAME Annapolis, Md. 21401
WILLIAM REESE & SONS MORTUARY, P.A. | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE
William Reese | |

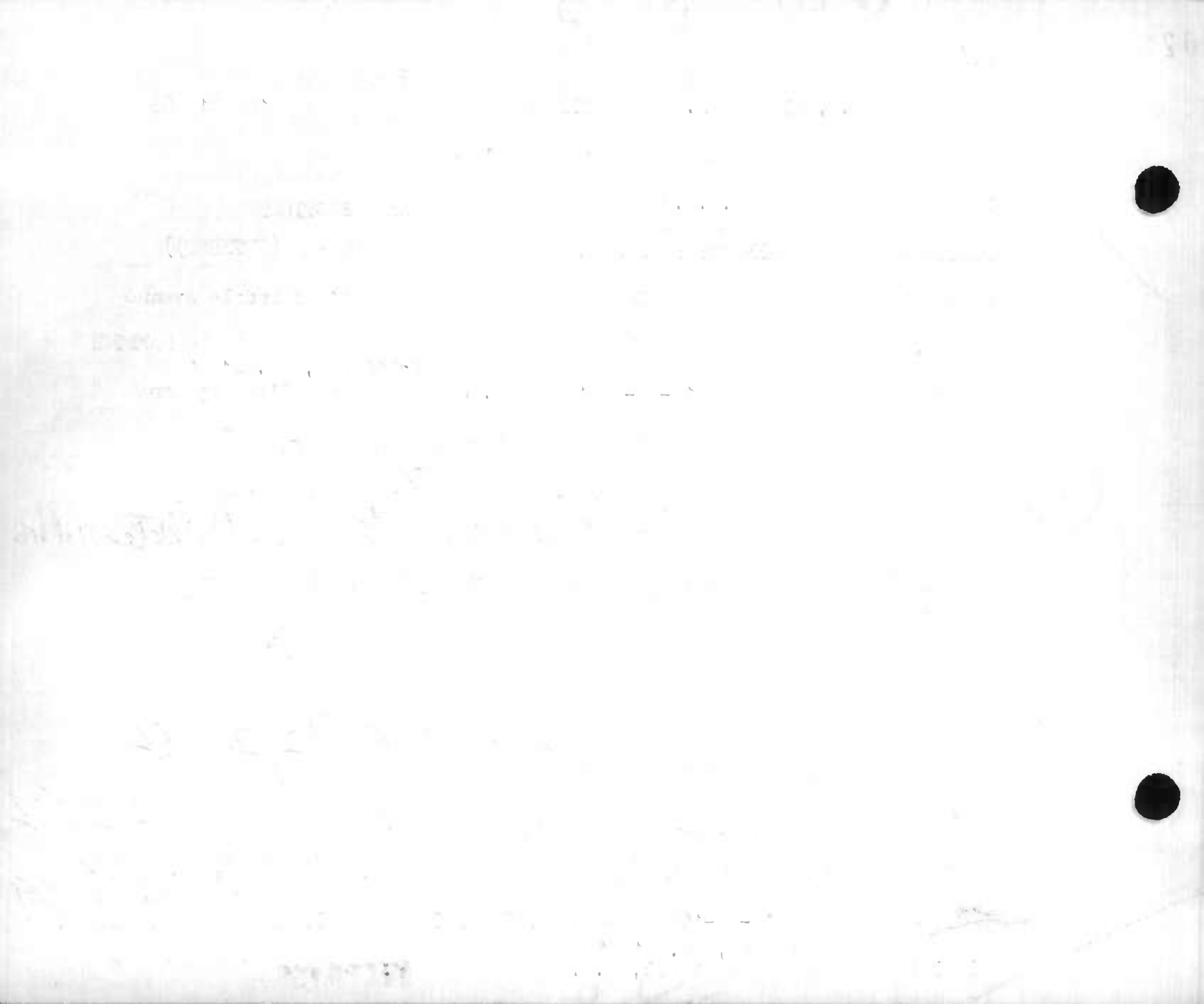
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their plates remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of occurrence.

BP



026861 DEC 12

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

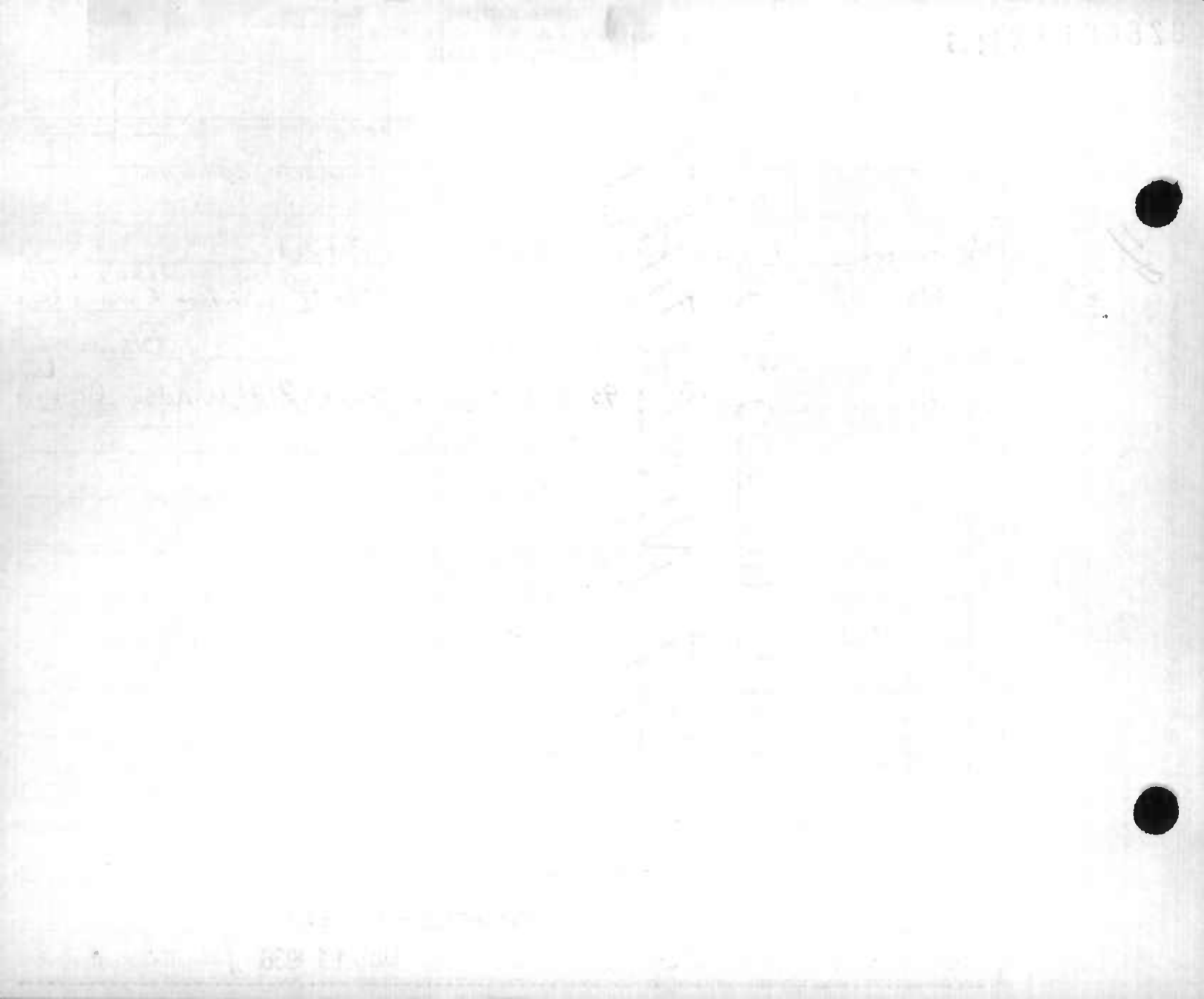
| | | | | | |
|---|--|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Edith R. ROBINSON | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 1 86 | | 2b. HOUR
9:10 AM |
| 3. SEX
F | 4. RACE
BLACK | 5. DATE OF BIRTH
MONTH DAY YEAR
3 4 16 | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS. MONTHS DAYS
70 | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
V | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTO. CITY MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Liberty Medical Center | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
Md | | 13b. COUNTY | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
2121 Windsor Garden Lane 21207 4213 |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Wilton Robinson | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Virginia Brown | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | |
| 16b. SOCIAL SECURITY NO.
215-01-99 | | 17. INFORMANT
Evangeline Brown | | ADDRESS
2121 Windsor Garden Lane | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) RESPIRATORY ARREST
DUE TO, OR AS A CONSEQUENCE OF (b) CVA
DUE TO, OR AS A CONSEQUENCE OF (c)
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
COLON CARCINOMATOSIS & METASTASIS | | | | | |
| 19a. DATE OF OPERATION
5/26/86 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
COLON CA | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/5/86 , 19 86 , to 12/7 , 19 86 , that (I) (we) last saw the deceased alive on 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Robert Francisco | | DEGREE
LIBERTY MEDICAL CENTER | | 22c. DATE SIGNED
12/1/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ROBERTO FRANCISCO | | 22e. ADDRESS
LIBERTY MEDICAL CENTER | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
12/12/86 | 23c. NAME OF CEMETERY OR CREMATORY
Crest Lawn Gardens of Memorial | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Howard Co Md | 24. FUNERAL DIRECTOR
NAME ADDRESS
March Funeral Home West 4300 Wabash Avenue | |
| 25a. DATE REC'D. BY REGISTRAR
DEC 11 1986 | | | 25b. REGISTRAR'S SIGNATURE
Julia Anderson-Randall | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of force.



026547 DEC -9 86

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | |
|--|--|--|--|--|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
MAE | | | 2a. DATE OF DEATH
MONTH DAY YEAR
DECEMBER 4, 1986 | | | 2b. HOUR
P M
5:30 P | | |
| 3 SEX
Female | | | 4. RACE
Black | | | 5. DATE OF BIRTH
MONTH DAY YEAR
5 1 26 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | 6. AGE (IN YEARS LAST BIRTHDAY)
MONTHS DAYS HOURS MIN.
60 YRS | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE JOHNS HOPKINS HOSPITAL | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD | | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a. STATE
MD | | | 13b. COUNTY | | | 13c. CITY OR TOWN
Baltimore | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Clement | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Isabelle Dickerson | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | | 16b. SOCIAL SECURITY NO.
216-20-3733 | | | 17. INFORMANT
ADDRESS
Louis Buckner 2120 Mura Street | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>pneumonia</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>lung cancer</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>3 days</u>
<u>6 mos.</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/1</u> 19 <u>86</u> , to <u>12/4</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>12/4</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE
<u>Lois E. Nielsen MD</u> DEGREE | | | | | | 22c. DATE SIGNED
<u>12/4/86</u> | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>LOIS E NIELSEN MD</u> | | | | | | 22e. ADDRESS | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
12/9/86 | | | 23c. NAME OF CEMETERY OR CREMATORY
Baltimore Cemetery | | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore MD | | | 24. FUNERAL DIRECTOR
NAME ADDRESS
Wm. C. March F/H, Inc. 1101 E. North Avenue | | | | | |
| 25a. DATE REC'D. BY REGISTRAR
DEC 8 1986 | | | | | | 25b. REGISTRAR'S SIGNATURE
<u>Julia Nelson-Randall</u> | | |

MEDICAL CERTIFICATION

29

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certificates, pages 1 and 2, and place them in the envelope provided with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

100-100000

COPIES
RECEIVED
FBI

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BOX 1011 ON EIGHT

100-100000

28741 DEC 31 1986

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 3 4 8 2 1

FOR
1. STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|---|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
Raymond Robinson | | | 2a. DATE OF DEATH MONTH DAY YEAR
12 22 86 | | 2b. HOUR
5:45 P.M. |
| 3. SEX
Male | 4. RACE
Black | 5. DATE OF BIRTH MONTH DAY YEAR
7 23 20 | | 6. AGE (IN YEARS LAST BIRTHDAY)
66 YRS. | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
IF UNDER 24 HRS. |
| 7a. BIRTHPLACE (STATE OR FOREIGN)
MD, USA | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore city MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Univ of MD Cancer Center | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | |
| 13a. STATE
MD | 13b. COUNTY
Balto | 13c. CITY OR TOWN
Balto | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
3514 Caton Ave 21229 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Raymond Robinson | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Mary Williams | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO.
220-05-8116 | | 17. INFORMANT ADDRESS
Lillie Robinson 3514 CATON AVE | |

| | | |
|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiopulm arrest
DUE TO, OR AS A CONSEQUENCE OF (b) terminal non-small cell carcinoma of lungs
DUE TO, OR AS A CONSEQUENCE OF (c) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
15 min |
|---|--|--|

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

| | | | | | |
|--|--|---|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/22 19 86 to 12/22 19 86 that (I) (we) last saw the deceased alive on 12/22 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (old) (did not) view the body after death. | | | | | |
| 27b. SIGNATURE
Austin Mo | | | | 27c. DATE SIGNED
12/22/86 | |
| 27d. PHYSICIAN'S NAME (TYPE OR PRINT)
Austin Mo | | | | 27e. ADDRESS
MD | |

| | | | |
|---|-----------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | 23b. DATE
12-29-86 | 23c. NAME OF CEMETERY OR CREMATORY
MARYLAND NATIONAL Mem | 23d. LOCATION CITY OR TOWN COUNTY STATE
BALTIMORE, MARYLAND |
|---|-----------------------|---|--|

| | | |
|--|--|---|
| 24. FUNERAL DIRECTOR NAME
Brown / Thompson F.H. | 25a. DATE REC'D. BY REGISTRAR
DEC 30 1986 | 25b. REGISTRAR'S SIGNATURE
Alicia Davidson-Randall |
|--|--|---|

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

100-10000

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DEC 30 1966

027371 DEC 17 1986

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | |
|---|-------------------------------------|---|--|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
TAMER J. ROBINSON | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12/14/86 | | | 2b. HOUR
9:25 AM | | |
| 3. SEX
F | 4. RACE
B | 5. DATE OF BIRTH
MONTH DAY YEAR
11/7/01 | 6. AGE (IN YEARS LAST BIRTHDAY)
85 YRS. | | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
N.C. | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Borsecan Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retiree | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
MD | | | 13b. COUNTY | | 13c. CITY OR TOWN
BALTO. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Samuel McCotter | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mima Harvey | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
220-03-9351 | | 17. INFORMANT
ADDRESS
Perry M. Hunter 4546 The Strand | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Sepsis,
DUE TO, OR AS A CONSEQUENCE OF
(b) Renal failure
DUE TO, OR AS A CONSEQUENCE OF
(c) ASCN | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/30, 19 86, to 12/14/86, that (I) (we) last saw the deceased alive on 12/13, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE
Mimi Oans MD | | | | | | DEGREE
MD | | 22c. DATE SIGNED
12/14/86 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MIMI OANS MD | | | | | | 22e. ADDRESS
905 NATIONAL AVE CMTL 2104 | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
12/19/86 | | 23c. NAME OF CEMETERY OR CREMATORY
Broad Creek Christian | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Oriental, N.C. | |
| 24. FUNERAL DIRECTOR
NAME
Wm C March F/H West | | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 16 1986 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Rudner |
| ADDRESS
4300 Wabash Ave | | | | | | | | |

MEDICAL CERTIFICATION

22

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed within 77 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of the event.

BP

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14

SECTION 1



12 19 86

RODERS

H.

1200

01 21 1953 84

X

BALTIMORE CITY

RECREATION

BUREAU OF

CUSTOMS

FACE GRANTING ROAD

BALTIMORE

BALTIMORE

MARYLAND

3405 GRANTING ROAD, BALTIMORE,

1953

LEE

ROSA

RODERS

ROBERT

MRS.

BALTIMORE, MARYLAND

214-14-681 EILEEN RODERS 3405 GRANTING ROAD, 21212

WM 11

YES

OWING KILLS, MARYLAND

RODERS - 21212 BALTIMORE, MARYLAND

21212 BALTIMORE, MARYLAND

026463 DEC 9 1986

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

86 34894

| | | | | | | | |
|---|--|--|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
<i>Genevieve F. Romeo</i> | | | 2a. DATE OF DEATH
MONTH DAY YEAR
<i>12 6 86</i> | | | 2b. HOUR
<i>4 40</i> P.M. | |
| 3. SEX
<i>Female</i> | | 4. RACE
<i>White</i> | | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>04 16 73</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>93</i> YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>Maryland</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Baltimore City</i> MD. | |
| 10. CITY OR TOWN OF DEATH
<i>Baltimore City</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT BY SUCH FACILITY, GIVE STREET ADDRESS)
<i>Simai Hospital</i> | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Homemaker</i> | |
| 13a. STATE
<i>Maryland</i> | | | | 13b. COUNTY
<i>Baltimore</i> | | 13c. CITY OR TOWN
<i>Maryland</i> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>George Feldpush</i> | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>Frederica Maderis</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>No</i> | | 16b. SOCIAL SECURITY NO.
<i>214-12-2443</i> | | 17. INFORMANT
ADDRESS
<i>Harry E. Ludwig 2669 Ocean Pines Berlin, MD</i> | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) *Respiratory Arrest 2° to Aspiration*

DUE TO, OR AS A CONSEQUENCE OF

(b) *Gastrointestinal Bleed*

DUE TO, OR AS A CONSEQUENCE OF

(c) *Severe Dehydration*

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

23 Hrs

48 Hrs

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

MEDICAL CERTIFICATION

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>December 5, 19 86</i> , to <i>December 6, 19 86</i> , that (I) (we) lost
saw the deceased alive on <i>December 6, 19 86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) did (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<i>Robert K. Roby</i> | | | | DEGREE
<i>MD</i> | | 22c. DATE SIGNED
<i>12/6/86</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>Robert K. Roby</i> | | | | 22e. ADDRESS
<i>Simai Hospital</i> | | | |

| | | | | | | | |
|--|--|--------------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<i>Burial</i> | | 23b. DATE
<i>12/09/1986</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Parkwood Cemetery</i> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Baltimore, Maryland</i> | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
<i>Leonard J. Ruck, Inc. Baltimore, Maryland</i> | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
<i>DEC 8 1986 [Signature]</i> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon paper with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



027356 DEC 1986

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|--|---|--|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Evelyn P. Roland | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 14 86 | | 2b. HOUR
M
M |
| 3. SEX
FEMALE | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH DAY YEAR
5 10 03 | | 6. AGE (IN YEARS (LAST BIRTHDAY))
83 YRS
IF UNDER 1 YEAR: MONTHS DAYS
IF UNDER 24 HRS: HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Chestertown, Md. | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Balto. City | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
3246 Keswick Rd. Balto., Md. 21211 | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Admins. Assist. | | 12b. KIND OF BUSINESS OR INDUSTRY
Amer. President |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | 13b. COUNTY
Baltimore | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Enoch Roland | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Florence Spicer | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
577-07-6008A | | 17. INFORMANT
ADDRESS
Mr. Regis Rheb 4215 Slater Avenue 21236 | |

18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cardiac arrest

DUE TO, OR AS A CONSEQUENCE OF

(b)

AscVD/known history of atnd fib and angina

DUE TO, OR AS A CONSEQUENCE OF

(c)

and possible ischemic HD/acute MI

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:

Severe anemia 2° to bleeding peptic ulcer - recent (11/86) gastric drainage empty/multiple possible polyps

| | | | |
|---|--|---|--|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USEFUL IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from October 29, 1986 to November 1, 1986 , that (I) (we) last saw the deceased alive on December 2, 1986 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
Allen Friedman | | 22c. DATE SIGNED
12/15/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Allen Friedman, MD 366-1838 | | 22e. ADDRESS
711 W. 40th St. Baltimore, Md. 4th Floor | |

| | | | |
|---|------------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
12-17-86 | 23c. NAME OF CEMETERY OR CREMATORY
Moreland Mem. Pk. | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Maryland |
| 24. FUNERAL DIRECTOR
NAME
Lassahn Funeral Home | | 25a. DATE REC'D. BY REGISTRAR
DEC 16 1986 | 25b. REGISTRAR'S SIGNATURE
India Tindren-Randall |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. (IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified by page 3.)

X



028063

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

34896

| | | | | | |
|--|---|--|---|--------------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | 2a. DATE OF DEATH | | 2b. HOUR | |
| Charles Henry Rohe Jr. | | December 20, 1986 | | M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE | 7. BALTIMORE CITY OR COUNTY OF DEATH | |
| Male | White | Oct. 22, 1911 | 75 | City MD | |
| 7a. BIRTHPLACE | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Md. | USA | NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | City MD | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION | 12a. USUAL OCCUPATION | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Baltimore | 4223 Harcourt Road | Ret. Carpenter | | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE | |
| Md. | | Baltimore | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 4223 Harcourt Road 21214 | |
| 14. FATHER'S NAME | 15. MOTHER'S MAIDEN NAME | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | | |
| Charles H. Rohe Sr. | Frances Vanik | no | | | |
| 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | |
| 219-05-1184 | | Mrs. Katherine Rohe Same | | | |
| 18. CAUSE OF DEATH | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1: DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) POSSIBLE ACUTE MYOCARDIAL INFARCTION | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: C.O.P.D., History of CARDIAC ARRYTHMIA | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| | | YES <input type="checkbox"/> NO <input type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | 21b. TIME OF INJURY | 21c. HOW INJURY OCCURRED | | | |
| (IF EITHER NOTIFY MEDICAL EXAMINER) | HOUR A.M. MONTH DAY YEAR | (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| | P.M. 19 | | | | |
| 21d. INJURY OCCURRED | 21e. PLACE OF INJURY | 21f. LOCATION | | | |
| WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7-16-86, 1986, to 12-20, 1986; that (I) (we) last saw the deceased alive on 11-19, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | |
| Donato A. Vargas MD | | M.D. ATTENDING PHYSICIAN | | 12-20-86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | 22f. REGISTRAR'S SIGNATURE | |
| Donato A. Vargas MD | | 4706 Harford Rd. Baltimore, Maryland | | Julia Davidson-Randall | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION | | |
| Burial | Dec. 23, 1986 | Oak Lawn | Baltimore Md. | | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| NAME ADDRESS | | DEC 22 1986 | | Julia Davidson-Randall | |
| Leonard J. Ruck Inc. Baltimore, Maryland | | | | | |

MEDICAL CERTIFICATION

BP

02672-1003

December 20, 1950

Henry John Dr.

Male

White

Dec. 10, 1911

Mr.

Mr.

Mr.

Mr. J. H. H.

Mr. J. H. H.

Mr. J. H. H.

Mr.

Mr.

Mr. J. H. H.

Charles H.

John Dr.

John

Mr. J. H. H. Dr. J. H. H. Dr. J. H. H.

Mr. J. H. H. Dr. J. H. H. Dr. J. H. H.



Mr. J. H. H. Dr. J. H. H. Dr. J. H. H.

Mr. J. H. H.

Mr. J. H. H.

Mr. J. H. H.

Mr. J. H. H. Dr. J. H. H. Dr. J. H. H.

Mr. J. H. H. Dr. J. H. H. Dr. J. H. H.

Mr.

Mr.

Mr.

Mr.

Mr. J. H. H. Dr. J. H. H. Dr. J. H. H.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the burial-transit permit from the back of this certificate and return it with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|--|---|--|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
CLARENCE E. RONE | | | 2a. DATE OF DEATH MONTH DAY YEAR
12 22 86 | | 2b. HOUR
1805 M |
| 3. SEX
Male | 4. RACE
Black | 5. DATE OF BIRTH MONTH DAY YEAR
April 13 - 99 | | 6. AGE (IN YEARS LAST BIRTHDAY)
59 YRS | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE City MD. | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
LOCH RAVEN VA HOSP. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Driver | 12b. KIND OF BUSINESS OR INDUSTRY
Trucking Co | |
| 13a. STATE
Md. | | 13b. COUNTY | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Charles Rone | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Mable Gill | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
W.W.2 248-16- 1512 | | 17. INFORMANT ADDRESS
Margaret Rone 2703 E. HOFFMAN ST. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>adenocarcinoma of lung</u>
DUE TO, OR AS A CONSEQUENCE OF (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost {
DUE TO, OR AS A CONSEQUENCE OF (c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____ | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, EARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Angela L. Corbin MD | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
12/22/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ANGELA CORBIN | | 22e. ADDRESS
LOCH RAVEN VA HOSP. BALT., MD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
12-29-86 | 23c. NAME OF CEMETERY OR CREMATORY
G.F.V. Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
OWINGS Mills, Md. | |
| 24. FUNERAL DIRECTOR
NAME
Randolph J. Collick | | ADDRESS
2436 Oliver St. | | 25a. DATE REC'D. BY REGISTRAR
DEC 30 1986 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
John Deaton-Randall | |

2014 12 24

Black Hills

Black Hills

Black Hills

Black Hills

Black Hills

Black Hills

Black Hills

Black Hills

Black Hills

027634 DEC 1986

FOR
STATE
REGISTRAR

Julia Ann Rose

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 3 4 8 9 8

REG. NO.

| | | | | | | | | | | | |
|---|--|--|--|---|--|--|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) <i>Julia</i> FIRST <i>Rose</i> MIDDLE LAST | | | 2a. DATE OF DEATH MONTH DAY YEAR
<i>12-16-86</i> | | 2b. HOUR
<i>11:40 P.M.</i> | | | | | | |
| 3. SEX
<i>Female</i> | | 4. RACE
<i>white</i> | | 5. DATE OF BIRTH
<i>Feb. 7, 1954</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>32</i> | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | 8. IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>Baltimore Md.</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Baltimore City</i> MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
<i>Baltimore</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Francis Scott Key Medical Center</i> | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Inspector</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>Rubber Products</i> | | | |
| 13a. STATE
<i>Maryland</i> | | | | | | 13b. CITY OR TOWN
<i>Baltimore</i> | | 13c. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13d. STREET ADDRESS / ZIP CODE
<i>2610 Holly Beach Rd. 21221</i> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>CHristian E. Sprouse</i> | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>Patricia Knighton</i> | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES OR UNKNOWN)
<i>No</i> | | 16b. SOCIAL SECURITY NO.
<i>220 62 2489</i> | | 17. INFORMANT
ADDRESS
<i>Richard J. Rose, Husband Same</i> | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>cardiorespiratory arrest</i>
DUE TO, OR AS A CONSEQUENCE OF
(b) <i>status post anoxic encephalopathy</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i></i> | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>a</i> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<i>P.M. 19</i> | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>December 3, 1986</i> to <i>December 16, 1986</i> that (I) (we) lost
saw the deceased alive on <i>December 16, 1986</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<i>R. Commiato</i> | | | | | | DEGREE | | 22c. DATE SIGNED
<i>12-17-86</i> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>R. Commiato</i> | | | | | | 22e. ADDRESS
<i>4940 Eastern Ave Baltimore, MD</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<i>Burial</i> | | | 23b. DATE
<i>12/20/86</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Oak Lawn Cemetery</i> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Baltimore Co., Md.</i> | | | | |
| 24. FUNERAL DIRECTOR
<i>Bruzdzinski Funeral Home</i> | | | | | | 25a. DATE REC'D. BY REGISTRAR
<i>DEC 17 1986</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Julia Davidson-Rachner</i> | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon and pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, or other traumatic event, a medical examiner must be notified of a death.

028135 DEC 29 1986

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

| | | | | | |
|--|--|---|---|--|---|
| 1 DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
DORA Roseborough | | | 2a. DATE OF DEATH MONTH DAY YEAR
12 19 86 | | 2b. HOUR
3:55 P.M. |
| 3 SEX
female | 4. RACE
BLACK | 5. DATE OF BIRTH
MONTH DAY YEAR
4 6 17 | 6. AGE (IN YEARS LAST BIRTHDAY)
69 YRS | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
North Carolina | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore CITY, MD. | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Federal Hill Nursing Center | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
N/A | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MD | | | 13b. COUNTY | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John Lawrence | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Nettie | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
214-26-0187 | 17. INFORMANT ADDRESS
Walter Roseborough 1533 East 36th Street | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>pub. cardiac arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Acute CVA</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Diabetes + Hypertension</u> | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>ASCVD</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8 Dec 18, 19 86</u> to <u>12/19, 19 86</u> that (I) (we) last saw the deceased alive on <u>12/18, 19 86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Ray Brodie, Jr | | | | 22c. DATE SIGNED
12/22/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Dr. Ray Brodie, Jr | | | | 22e. ADDRESS
844 N. CAREY ST. 21217 | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
12/27/86 | | 23c. NAME OF CEMETERY OR CREMATORY
King Memorial Park | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Randallstown, Md. | | 23e. DATE REC'D. BY REGISTRAR
DEC 23 1986 | | | |
| 24. FUNERAL DIRECTOR
NAME
March Funeral Homes | | ADDRESS
1101 East North Avenue | | 25. REGISTRAR'S SIGNATURE
[Signature] | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 24 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

581001

20% COTTON FIBER



BLENDED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other circumstance, the medical examiner must be notified and a post-mortem examination required.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 86 34900 | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Anna LaCotti Rouch | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
December 28, 1986 | | 2b. HOUR
10:00 AM | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
Feb. 24, 1909 | | 6. AGE (IN YEARS LAST BIRTHDAY)
77 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
21237 101 Philadelphia Avenue | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
home | |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE 13b. COUNTY 13c. CITY OR TOWN
Md. Balto. | | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
21237 101 Philadelphia Ave | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Paul LaCotti | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Catherine Pizzata | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
212-01-9260 | | 17. INFORMANT ADDRESS
21220 D Mr. Paul LaCotti, 107 Wawmeter Dr. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Pulmonary arrest
DUE TO, OR AS A CONSEQUENCE OF (b) unknown - found dead
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c) Carcinomatous | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. a
NIA | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHERE <input type="checkbox"/> AT HOME <input type="checkbox"/> NO: WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5:30 , 19 85 , to 12-19-1986 , that (I) (we) last saw the deceased alive on 12-19-1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
N. Khanna | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12-29-86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
N. Khanna, M.D. | | | | 22e. ADDRESS
617-G Stemmurs Run Rd. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
12-31-86 | | 23c. NAME OF CEMETERY OR CREMATORY
Sacred Heart Jesus | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Md. | |
| 24. FUNERAL DIRECTOR
Joseph N. Zannino, 263 S. Conkling St. 21224 | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 30 1986 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | |

BP

026987 DEC 11 1986

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | | | | |
|--|---------|---|--|--|--|---|--|---|--|-------|--|-----------------------------------|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH | | MONTH | | DAY | | YEAR | | 2b. HOUR | |
| Levon | | Rouse | | | | | | 12 | | 6 | | 1986 | | | | M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | 7c. DATE PRONOUNCED DEAD | | MONTH | | DAY | | YEAR | | 2d. HOUR | |
| Male | Black | 3/19/53 | | 33 YRS. | | | | 12 | | 6 | | 1986 | | | | 5:45 PM | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | |
| South Carolina | | USA | | | | Baltimore City MD | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Baltimore | | 1903 E. Chase Street | | | | | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | | | | | |
| Md. | | | | Balto. | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 21213 1903 E. Chase Street | | | | | | | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | |
| FIRST MIDDLE LAST | | | | FIRST MIDDLE LAST | | | | | | | | | | | | | |
| Jasper Haynes | | | | Evelyn Rouse | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT ADDRESS | | | | | | | | | |
| no | | | | | | | | Clarice Foxworth 4270 Rokeby Rd. | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Cirrhosis of liver | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause fast | | | | | | | | | | | | | | | | | |
| (b) | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | 20. AUTOPSY? | | | |
| | | | | | | | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | |
| | | | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | | | | | |
| | | | | P.M. 19 | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION | | | | | | | | | |
| | | | | | | | | STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | TITLE (SPECIFY) | | | | | | | | | | DATE SIGNED | | | |
| Margarita A. Korell, M.D. | | | | M.D. Assistant MEDICAL EXAMINER | | | | | | | | | | 12/7/86 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS | | | | | | | | | | | | | |
| Margarita A. Korell, M.D. | | | | 111 Penn St. Balto. MD. | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION | | | | | |
| Burial | | | | 12/13/86 | | | | Church Cemetery | | | | Loris, S. Carolina | | | | | |
| 24. FUNERAL DIRECTOR | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | |
| NAME ADDRESS | | | | DEC 11 1986 | | | | Julia Davidson Padua | | | | | | | | | |
| Charles A. Rice FSPA 1300 Eutaw Pl. | | | | | | | | | | | | | | | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201
 07/84 BP
 25M
 DHMH - 17
 (VR A15 ME (5))

052111 - 11-3

1

2-10-11, 11-21

026346 DEC 1

Items, 13a, 21a, -22a, 12/19/86 STATE OF MARYLAND
 FOR REG-622, M.E.,/Gbj.
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | |
|--|---------------------|--|---|---|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Cleveland Rowe | | | 2a. DATE KNOWN OF DEATH
<input checked="" type="checkbox"/> MONTH DAY YEAR
12 2 1986 | | | 2b. HOUR
M | | |
| 3. SEX
M | 4. RACE
B | 5. DATE OF BIRTH
MONTH DAY YEAR
8 22 59 | 6. AGE (IN YEARS)
(BY BIRTHDAY)
27 YRS. | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | 7c. DATE PRONOUNCED DEAD
12 2 1986 | 2d. HOUR
7:10A | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD. | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
1516 N. Bradford Street | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
MARKET UNLOAD., INC | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
MD | | 13b. COUNTY
BALTO. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
2233 E. FEDERAL ST. 21213 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
JAMES ROWE | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
JESSIE LEE | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
NO | | | 16b. SOCIAL SECURITY NO.
216889717 | | | 17. INFORMANT ADDRESS
JAMES ROWE 2233 E. FEDERAL ST. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Narcotic intoxication
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
Primary | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 12 2 1986 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
Subject used drugs | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
unknown | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
unknown | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> . | | | | | | | | |
| ACTUAL SIGNATURE
<i>William M. Zane</i> | | | TITLE (SPECIFY)
M.D. Assistant | | | DATE SIGNED
12/2/86 | | |
| EXAMINER'S NAME (TYPE OR PRINT)
William M. Zane, M.D. | | | ADDRESS
111 Penn St. Balto.MD. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
12 6 86 | | 23c. NAME OF CEMETERY OR CREMATORY
MT. CALVARY CEMETERY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
ANNE ARUNDEL MD | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
MARCH F/H 1101 E. NORTH AVE. | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 5 1986 | | 25b. REGISTRAR'S SIGNATURE
<i>Julia Davidson-Randall</i> | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MDHMH - 17
(VR A15 ME (5))

0509 0 11-100

RESIST MOTION 4000

WINTER 1940



026453 DEC-1986

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | |
|---|--|--|--|--|-----------------------------|---|
| 1 DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
NORA S. Royster | | | 2a DATE OF DEATH
MONTH DAY YEAR
12-5-86 | | 2b HOUR
9:45 A.M. | |
| 3 SEX
Female | | 4 RACE
B | | 5 DATE OF BIRTH
MONTH DAY YEAR
05 12 21 | | 6 AGE (IN YEARS LAST BIRTHDAY)
65 YRS |
| 7a BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
VA. | | 7b CITIZEN OF WHAT COUNTRY?
USA | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Balto City MD. |
| 10 CITY OR TOWN OF DEATH
Balto. MD. | | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
North Chicks Gen. Hosp | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | | 12b KIND OF BUSINESS OR INDUSTRY |
| 13a STATE
MD. | | 13b COUNTY | | 13c CITY OR TOWN
Balto. | | 13d INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
Solomon Tuck | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Lizzie Faulkner | | 13e STREET ADDRESS / ZIP CODE
5100 Penbridge Ave. 21215 | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b SOCIAL SECURITY NO.
241-26-0245 | | 17 INFORMANT
ADDRESS
William K. Royster 5100 Penbridge Ave | | |
| 18 CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).
PART 1: DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Cardiorespiratory Arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) Central Metastases
DUE TO, OR AS A CONSEQUENCE OF
(c) Pancreatic Carcinoma
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a I certify that (I) (this hospital) attended the deceased from 11-28 , 19 86 , to 12-5 , 19 86 , that (I) (we) lost saw the deceased alive on 12-5 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b SIGNATURE
J.T. Rave, M.D. | | DEGREE
M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c DATE SIGNED
12/5/86 |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)
J.T. Rave, M.D. | | 22e ADDRESS
North Chicks Gen. Hospital | | | | |
| 23a BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b DATE
12/10/86 | | 23c NAME OF CEMETERY OR CREMATORY
Garrison Forest Vet | | 23d LOCATION
CITY OR TOWN COUNTY STATE
Owings Mills MD |
| 24 FUNERAL DIRECTOR
NAME ADDRESS
March Funeral Home West 4300 Wabash Avenue | | | | 25a DATE RECEIVED BY REGISTRAR
DEC 8 1986 | | |
| | | | | 25b REGISTRAR'S SIGNATURE
John D. R. Rindner | | |

MEDICAL CERTIFICATION

99

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove page 4 and return it to the State Department of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body. Page 2 should be filed with the funeral director. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trauma, the medical examiner must be notified and a medical investigation conducted.



02784 | DEC 23 1986

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 3 4 9 0 4

FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|---|--|---|--|--|--|---|--|--|--|
| 1 DECEASED NAME
(TYPE OR PRINT)
Blondell | | FIRST
RUCKER | | LAST | | 2a DATE OF DEATH
MONTH DAY YEAR
December 17, 1986 | | 2b HOUR
1:50^A | |
| 3 SEX
F | | 4 RACE
B | | 5. DATE OF BIRTH
MONTH YEAR
11 18 30 | | 6 AGE (IN YEARS LAST BIRTHDAY)
56 | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
S C. | | 7b CITIZEN OF WHAT COUNTRY?
USA | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10 CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Maryland General Hospital | | | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE | | 12b KIND OF BUSINESS OR INDUSTRY | |
| 13a STATE
MD | | | | 13b COUNTY
BALTO. | | 13c CITY OR TOWN
BALTO. | | 13d INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e STREET ADDRESS / ZIP CODE
2736 PARKWOOD AVE. 21217 | | | | | | | | | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
EZEKIEL WILLIAMS | | | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ETHEL ? | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b SOCIAL SECURITY NO.
248186082 | | 17 INFORMANT ADDRESS
JAMES RUCKER, SR, 2736 PARKWOOD AVE. | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute renal failure; Hepatic encephalopathy.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost
(b) Disseminated intravascular coagulopathy
(c) Metastatic malignant disease; (primary site unknown) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: NO | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from December 12, 1986 , to December 17, 1986 , that (I/we) lost
saw the deceased alive on December 17, 1986 , and that in (my/our) opinion death occurred on the date and hour and from the causes stated
above <input checked="" type="checkbox"/> (we) (did) (not) view the body after death. | | | | | | | | | |
| 22b SIGNATURE
Henri Nammour | | | | DEGREE
M.D. | | | | 22c DATE SIGNED
12-17-86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Henri Nammour, M.D. | | | | 22e ADDRESS
c/o Maryland General Hospital | | | | | |
| 23a BURIAL, CREMATION, REMOVAL
BURIAL | | 23b. DATE
12-22-86 | | 23c. NAME OF CEMETERY OR CREMATORY
BALTIMORE NATIONAL | | 23d LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE MD | | | |
| 24 FUNERAL DIRECTOR
NAME
MARCH FUNERAL HOME 1101 E. NORTH AVE. | | | | 25a DATE REC'D. BY REGISTRAR
DEC 19 1986 | | 25b REGISTRAR'S SIGNATURE
John Gordon | | | |

MEDICAL CERTIFICATION

29

BP
DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and is properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REGISTRAR

REG. NO.

| | | | | | | | | | | | |
|---|--|---|--|---|---|--|---|--|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Edythe Wilson Russell | | | 2a. DATE OF DEATH
MONTH DAY YEAR
December 16, 1986 | | | 2b. HOUR
8:30 P.M. | | | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
February 13, 1917 | | 6. AGE (IN YEARS LAST BIRTHDAY)
69 YRS | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Deaton Hospital + Medical Center | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
Own Home | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | 13b. COUNTY
A A Co. | | 13c. CITY OR TOWN
Glen Burnie | | 13d. INSIDE CITY LIMITS?
YES NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
102 Crain Highway Apt 874 21061 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Harry Webster | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ada (Unknown) | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No NA | | | | 16b. SOCIAL SECURITY NO.
214.20.8505 | |
| 17. INFORMANT (Nephew)
Emmett N. Wilson | | | ADDRESS
319 Roosevelt Ave.
Glen Burnie, Md. 21061 | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiopulmonary insufficiency</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>multiple sclerosis</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause lost | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED
(ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>12/3</u> , 19 <u>86</u> , to <u>12/16</u> , 19 <u>86</u> , that (I) (we) lost
saw the deceased alive on <u>12/16</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Harold Blumstein, MD | | | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED
12/16/86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Harold Blumstein | | | | | | 22e. ADDRESS
3001 S. Nantuxa St | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
Dec 19, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Brooklyn Park A A Co. Md. | | | | |
| 24. FUNERAL DIRECTOR
NAME
Singleton Funeral Home Glen Burnie, Maryland | | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 23 1986 | | 25b. REGISTRAR'S SIGNATURE
Lin. Davidson-Randall | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please enclose in the permit pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP _____

20% COTTON 100%

WINTER

11-12-51

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11-12-51



[Handwritten signature]

028898 JAN 20

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their place in the funeral home papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other significant event, the medical examiner must be notified at once.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | |
|--|--|--|--|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) XXXXXXXX VINCENT | | | 2a. DATE OF DEATH MONTH DAY YEAR
DECEMBER 23, 1986 | | | 2b. HOUR
11:20am | | |
| 3. SEX
MALE | | | 5. DATE OF BIRTH
JAN. 1, 1904 | | | 6. AGE (IN YEARS LAST BIRTHDAY)
82 YRS | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
POLAND | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
CHURCH HOSPITAL | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
LABORER | | |
| 13a. STATE
MARYLAND | | | 13b. COUNTY
BALTIMORE | | | 13c. STREET ADDRESS / ZIP CODE
1629 SHAKESPEARE ST. 21231 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
JOSEPH RYDZEWSKI | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
UNKNOWN | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | | 16b. SOCIAL SECURITY NO.
217051568 | | | 17. INFORMANT ADDRESS
IRIS CRAWFORD 837 EWING DR. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST
DUE TO, OR AS A CONSEQUENCE OF
(b) COMPLETE HEART BLOCK
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c) MYOCARDIAL INFACTION INFARCTION | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
10 MINUTES
3 DAYS
3 DAYS | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: FAILURE TO PACE, CONGESTIVE HEART FAILURE, PNEUMONIA | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NO! WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from DECEMBER 13, 1986 to DECEMBER 23, 1986 that (I) (we) first saw the deceased alive on DECEMBER 23, 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE
Carol S. Ramsy | | | DEGREE
D.O. | | | 22c. DATE SIGNED | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
CAROL S. RAMSY, D.O. | | | 22e. ADDRESS
CHURCH HOSPITAL CORPORATION
100 N. BROADWAY, BALTIMORE, MD. 21231 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(TYPE)
BURIAL | | | 23b. DATE
12/27/86 | | 23c. NAME OF CEMETERY OR CREMATORY
HOLY ROSARY CEM | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE MD | |
| 24. FUNERAL DIRECTOR
NAME
RAYMOND L. KACZOROWSKI | | | ADDRESS
2525 FLEET ST | | | 25a. DATE REC'D. BY REGISTRAR
DEC 30 1986 | | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE
Antia Davidson-Randall | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card pages 1 and 2 and 3 and 4 and 5 and 6 and 7 and 8 and 9 and 10 and 11 and 12 and 13 and 14 and 15 and 16 and 17 and 18 and 19 and 20 and 21 and 22 and 23 and 24 and 25 and 26 and 27 and 28 and 29 and 30 and 31 and 32 and 33 and 34 and 35 and 36 and 37 and 38 and 39 and 40 and 41 and 42 and 43 and 44 and 45 and 46 and 47 and 48 and 49 and 50 and 51 and 52 and 53 and 54 and 55 and 56 and 57 and 58 and 59 and 60 and 61 and 62 and 63 and 64 and 65 and 66 and 67 and 68 and 69 and 70 and 71 and 72 and 73 and 74 and 75 and 76 and 77 and 78 and 79 and 80 and 81 and 82 and 83 and 84 and 85 and 86 and 87 and 88 and 89 and 90 and 91 and 92 and 93 and 94 and 95 and 96 and 97 and 98 and 99 and 100 and 101 and 102 and 103 and 104 and 105 and 106 and 107 and 108 and 109 and 110 and 111 and 112 and 113 and 114 and 115 and 116 and 117 and 118 and 119 and 120 and 121 and 122 and 123 and 124 and 125 and 126 and 127 and 128 and 129 and 130 and 131 and 132 and 133 and 134 and 135 and 136 and 137 and 138 and 139 and 140 and 141 and 142 and 143 and 144 and 145 and 146 and 147 and 148 and 149 and 150 and 151 and 152 and 153 and 154 and 155 and 156 and 157 and 158 and 159 and 160 and 161 and 162 and 163 and 164 and 165 and 166 and 167 and 168 and 169 and 170 and 171 and 172 and 173 and 174 and 175 and 176 and 177 and 178 and 179 and 180 and 181 and 182 and 183 and 184 and 185 and 186 and 187 and 188 and 189 and 190 and 191 and 192 and 193 and 194 and 195 and 196 and 197 and 198 and 199 and 200 and 201 and 202 and 203 and 204 and 205 and 206 and 207 and 208 and 209 and 210 and 211 and 212 and 213 and 214 and 215 and 216 and 217 and 218 and 219 and 220 and 221 and 222 and 223 and 224 and 225 and 226 and 227 and 228 and 229 and 230 and 231 and 232 and 233 and 234 and 235 and 236 and 237 and 238 and 239 and 240 and 241 and 242 and 243 and 244 and 245 and 246 and 247 and 248 and 249 and 250 and 251 and 252 and 253 and 254 and 255 and 256 and 257 and 258 and 259 and 260 and 261 and 262 and 263 and 264 and 265 and 266 and 267 and 268 and 269 and 270 and 271 and 272 and 273 and 274 and 275 and 276 and 277 and 278 and 279 and 280 and 281 and 282 and 283 and 284 and 285 and 286 and 287 and 288 and 289 and 290 and 291 and 292 and 293 and 294 and 295 and 296 and 297 and 298 and 299 and 300 and 301 and 302 and 303 and 304 and 305 and 306 and 307 and 308 and 309 and 310 and 311 and 312 and 313 and 314 and 315 and 316 and 317 and 318 and 319 and 320 and 321 and 322 and 323 and 324 and 325 and 326 and 327 and 328 and 329 and 330 and 331 and 332 and 333 and 334 and 335 and 336 and 337 and 338 and 339 and 340 and 341 and 342 and 343 and 344 and 345 and 346 and 347 and 348 and 349 and 350 and 351 and 352 and 353 and 354 and 355 and 356 and 357 and 358 and 359 and 360 and 361 and 362 and 363 and 364 and 365 and 366 and 367 and 368 and 369 and 370 and 371 and 372 and 373 and 374 and 375 and 376 and 377 and 378 and 379 and 380 and 381 and 382 and 383 and 384 and 385 and 386 and 387 and 388 and 389 and 390 and 391 and 392 and 393 and 394 and 395 and 396 and 397 and 398 and 399 and 400 and 401 and 402 and 403 and 404 and 405 and 406 and 407 and 408 and 409 and 410 and 411 and 412 and 413 and 414 and 415 and 416 and 417 and 418 and 419 and 420 and 421 and 422 and 423 and 424 and 425 and 426 and 427 and 428 and 429 and 430 and 431 and 432 and 433 and 434 and 435 and 436 and 437 and 438 and 439 and 440 and 441 and 442 and 443 and 444 and 445 and 446 and 447 and 448 and 449 and 450 and 451 and 452 and 453 and 454 and 455 and 456 and 457 and 458 and 459 and 460 and 461 and 462 and 463 and 464 and 465 and 466 and 467 and 468 and 469 and 470 and 471 and 472 and 473 and 474 and 475 and 476 and 477 and 478 and 479 and 480 and 481 and 482 and 483 and 484 and 485 and 486 and 487 and 488 and 489 and 490 and 491 and 492 and 493 and 494 and 495 and 496 and 497 and 498 and 499 and 500 and 501 and 502 and 503 and 504 and 505 and 506 and 507 and 508 and 509 and 510 and 511 and 512 and 513 and 514 and 515 and 516 and 517 and 518 and 519 and 520 and 521 and 522 and 523 and 524 and 525 and 526 and 527 and 528 and 529 and 530 and 531 and 532 and 533 and 534 and 535 and 536 and 537 and 538 and 539 and 540 and 541 and 542 and 543 and 544 and 545 and 546 and 547 and 548 and 549 and 550 and 551 and 552 and 553 and 554 and 555 and 556 and 557 and 558 and 559 and 560 and 561 and 562 and 563 and 564 and 565 and 566 and 567 and 568 and 569 and 570 and 571 and 572 and 573 and 574 and 575 and 576 and 577 and 578 and 579 and 580 and 581 and 582 and 583 and 584 and 585 and 586 and 587 and 588 and 589 and 590 and 591 and 592 and 593 and 594 and 595 and 596 and 597 and 598 and 599 and 600 and 601 and 602 and 603 and 604 and 605 and 606 and 607 and 608 and 609 and 610 and 611 and 612 and 613 and 614 and 615 and 616 and 617 and 618 and 619 and 620 and 621 and 622 and 623 and 624 and 625 and 626 and 627 and 628 and 629 and 630 and 631 and 632 and 633 and 634 and 635 and 636 and 637 and 638 and 639 and 640 and 641 and 642 and 643 and 644 and 645 and 646 and 647 and 648 and 649 and 650 and 651 and 652 and 653 and 654 and 655 and 656 and 657 and 658 and 659 and 660 and 661 and 662 and 663 and 664 and 665 and 666 and 667 and 668 and 669 and 670 and 671 and 672 and 673 and 674 and 675 and 676 and 677 and 678 and 679 and 680 and 681 and 682 and 683 and 684 and 685 and 686 and 687 and 688 and 689 and 690 and 691 and 692 and 693 and 694 and 695 and 696 and 697 and 698 and 699 and 700 and 701 and 702 and 703 and 704 and 705 and 706 and 707 and 708 and 709 and 710 and 711 and 712 and 713 and 714 and 715 and 716 and 717 and 718 and 719 and 720 and 721 and 722 and 723 and 724 and 725 and 726 and 727 and 728 and 729 and 730 and 731 and 732 and 733 and 734 and 735 and 736 and 737 and 738 and 739 and 740 and 741 and 742 and 743 and 744 and 745 and 746 and 747 and 748 and 749 and 750 and 751 and 752 and 753 and 754 and 755 and 756 and 757 and 758 and 759 and 760 and 761 and 762 and 763 and 764 and 765 and 766 and 767 and 768 and 769 and 770 and 771 and 772 and 773 and 774 and 775 and 776 and 777 and 778 and 779 and 780 and 781 and 782 and 783 and 784 and 785 and 786 and 787 and 788 and 789 and 790 and 791 and 792 and 793 and 794 and 795 and 796 and 797 and 798 and 799 and 800 and 801 and 802 and 803 and 804 and 805 and 806 and 807 and 808 and 809 and 810 and 811 and 812 and 813 and 814 and 815 and 816 and 817 and 818 and 819 and 820 and 821 and 822 and 823 and 824 and 825 and 826 and 827 and 828 and 829 and 830 and 831 and 832 and 833 and 834 and 835 and 836 and 837 and 838 and 839 and 840 and 841 and 842 and 843 and 844 and 845 and 846 and 847 and 848 and 849 and 850 and 851 and 852 and 853 and 854 and 855 and 856 and 857 and 858 and 859 and 860 and 861 and 862 and 863 and 864 and 865 and 866 and 867 and 868 and 869 and 870 and 871 and 872 and 873 and 874 and 875 and 876 and 877 and 878 and 879 and 880 and 881 and 882 and 883 and 884 and 885 and 886 and 887 and 888 and 889 and 890 and 891 and 892 and 893 and 894 and 895 and 896 and 897 and 898 and 899 and 900 and 901 and 902 and 903 and 904 and 905 and 906 and 907 and 908 and 909 and 910 and 911 and 912 and 913 and 914 and 915 and 916 and 917 and 918 and 919 and 920 and 921 and 922 and 923 and 924 and 925 and 926 and 927 and 928 and 929 and 930 and 931 and 932 and 933 and 934 and 935 and 936 and 937 and 938 and 939 and 940 and 941 and 942 and 943 and 944 and 945 and 946 and 947 and 948 and 949 and 950 and 951 and 952 and 953 and 954 and 955 and 956 and 957 and 958 and 959 and 960 and 961 and 962 and 963 and 964 and 965 and 966 and 967 and 968 and 969 and 970 and 971 and 972 and 973 and 974 and 975 and 976 and 977 and 978 and 979 and 980 and 981 and 982 and 983 and 984 and 985 and 986 and 987 and 988 and 989 and 990 and 991 and 992 and 993 and 994 and 995 and 996 and 997 and 998 and 999 and 1000

IMPORTANT: If item 21 is marked on item 18 state any injury, or other traumatic event, the medical examiner must be notified of such.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Michael (NMI) Salanik | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12/24/86 | | | |
| 3 SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
11 8 1896 | | 7b. HOUR
4:45 PM | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Austria | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 6. AGE (IN YEARS LAST BIRTHDAY)
90 | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Garden Village Nursing Home | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD. | |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | 13b. CITY OR TOWN
Baltimore | | 13c. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 12b. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Press Operator | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | 13d. STREET ADDRESS / ZIP CODE
7861 Oakdale Avenue 21237 | | 17b. KIND OF BUSINESS OR INDUSTRY
Metal Stamping | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
--- | | 17. INFORMANT
George Salanik | | ADDRESS
7861 Oakdale Ave. 21237 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Cardio-pulmonary Arrest
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cardiovascular Disease
DUE TO, OR AS A CONSEQUENCE OF (c) years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Carcinoma of the Larynx; Alzheimer's Disease | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
8:11 P.M. 19 86 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | 21d. LOCATION
STREET CITY OR TOWN COUNTY STATE
4900 Belair Road Baltimore MD | |
| 21e. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21f. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21g. LOCATION
STREET CITY OR TOWN COUNTY STATE
4900 Belair Road Baltimore MD | | 21h. LOCATION
STREET CITY OR TOWN COUNTY STATE
4900 Belair Road Baltimore MD | |
| 22a. I certify that (I) (as hospital) attended the deceased from 12/24/86 to 12/24/86 , that (I) (we) last saw the deceased alive on 12/24/86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Albert B. Bradley | | | | DEGREE
MD | | 22c. DATE SIGNED
12/26/1986 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Albert B. Bradley | | | | 22e. ADDRESS
4900 Belair Road | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
12/27/1986 | | 23c. NAME OF CEMETERY OR CREMATORY
St. Andrew's Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore MD | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Walter Brooks Bradley, Inc. Balto., MD 21222 | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 29 1986 | | 25b. REGISTRAR'S SIGNATURE
Julia Anderson-Richter | |

BP

027375 DEC 14 1986

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

| | | | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|---|--|---|--|--|--|------------------|--|--------------------------------------|--|-------|--|----------|--|------|--|----------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2b. DATE KNOWN OF DEATH | | MONTH | | DAY | | YEAR | | 2d. HOUR | | | | | |
| SHARIF | | ABDUL | | SAMAD | | | | 12-13-86 | | | | | | | | am | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | MONTH | | DAY | | YEAR | | 2d. HOUR | |
| Male | | Black | | 7 23 84 | | 2 YRS. | | MONTHS | | DAYS | | HOURS | | MIN. | | 12-13-86 | | | | 11:07 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | NEVER MARRIED | | WIDOWED | | DIVORCED | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | MD. | |
| Md. | | USA | | | | | | | | | | Baltimore City | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | |
| Baltimore | | University Hospital | | | | | | | | | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | | | | | | | | | |
| Md. | | | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 4153 Fairview Avenue | | 21216 | | | | | | | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | | | | |
| Ishmail | | Abdus-Samad | | Saidah | | Baskerville | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | | | | | | | | | |
| No | | 219-06-4352 | | Ishmail Abdus-Samad | | 4153 Fairview Ave | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | PART I DEATH WAS CAUSED BY: | | IMMEDIATE CAUSE (a) | | Multiple injuries | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | |
| 8147 | | | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost | | | | (b) | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
| | | | | (c) | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | | | | | |
| | | 9:30AM 12-13-86 | | pedestrian struck by a car | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | | STREET | | CITY OR TOWN | | COUNTY | | STATE | | | | | | | | | |
| | | street | | 4100 blk. Fairview Avenue | | Baltimore, Md. | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | |
| TITLE (SPECIFY) | | DATE SIGNED | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | M.D. | | Chief | | MEDICAL EXAMINER | | | | | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | | | | | | | | | | | | | | | | | | |
| John E. Smialek, M.D. | | 111 Penn Street | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | CITY OR TOWN | | COUNTY | | STATE | | | | | | | | | |
| Burial | | 12/15/86 | | Masjis Al-Rahmah Cem. | | Baltimore Co., Md. | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | NAME | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | |
| Wm C March F/H West | | 4300 Wabash Ave. | | | | DEC 16 1986 | | [Signature] | | | | | | | | | | | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM BM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSFER PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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2025 OCT 16 11:11 AM

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2025

028015 DEC 23 1986

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|---|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
James Samuels | | | 2a. DATE OF DEATH
MONTH DAY YEAR
13 14 86 | | 2b. HOUR
1:50 PM |
| 3. SEX
Male | 4. RACE
Black | 5. DATE OF BIRTH
MONTH DAY YEAR
3 12 12 | | 6. AGE (IN YEARS LAST BIRTHDAY)
74 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
S.C. | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
City MD | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Sina | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
laborer | | 12b. KIND OF BUSINESS OR INDUSTRY
Ess Key |
| 13a. STATE
MD | | 13b. COUNTY | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Unkn | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Unkn | | 16. SOCIAL SECURITY NO.
238-03-7970 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 17. INFORMANT
Mary Marine | | ADDRESS
6608 Parr Ave | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) massive Heart Block / Myocardial Infarction
DUE TO, OR AS A CONSEQUENCE OF
(c) Myocardial Infarction
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/13/86 to 12/14/86, that (I) (we) last saw the deceased alive on 12/14/86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Brookins - Reddix | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
12/14/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
N. Brookins Reddix | | 22e. ADDRESS
Sina Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | 23b. DATE
12/18/86 | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Zion Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Landsdown, Md. | |
| 24. FUNERAL DIRECTOR
NAME
Wm C March F/H West | | ADDRESS
4300 Wabash Ave. | | 25a. DATE REC'D. BY REGISTRAR
DEC 19 1986 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
Julia Benson-Randall | |

MEDICAL CERTIFICATION

776
42
23
200

29

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove each page from this certificate and place it in the folder provided with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

RECEIVED

UNITED STATES

1954



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cause of death papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or other final disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical examination must be obtained.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

| | | | | | |
|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
GEORGE W SAMPSON | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 6 86 | | 2b. HOUR
5:00 P.M. | |
| 3. SEX
MALE | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
10 18 21 | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
65 YRS | | 7. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
S. CAROLINA
U.S.A. | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
BON SECOUR Hosp. | | 12a. USUAL OCCUPATION
(PE OF WORK FOR MOST OF WORKING LIFE)
Fireman Oiler | |
| 12b. KIND OF BUSINESS OR INDUSTRY
B&O Railroad | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MD | | 13b. COUNTY
J | | 13c. CITY OR TOWN
Baltimore | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
PRESSLEY SAMPSON | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Nolia Nagwood | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
247-16-8410 | | 17. INFORMANT
ADDRESS
Ella Sampson 2502 Mosher St. 21216 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Extensive Squamous cell CA of lung</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>chronic obstructive pulmonary disease</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u></u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>11/25/86</u> , 19 <u>86</u> , to <u>12/6</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>12/6</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>Michael Kazak</u> | | DEGREE | | 22c. DATE SIGNED
12/6/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MICHAEL KAZAK | | 22e. ADDRESS
3001 SOUTH HAMOVER ST. BALT. MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
12/12/86 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Brooklyn A.A. Md. | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Chas. A. Rice FSPA | | ADDRESS
1300 Eutaw Place | | 25a. DATE REC'D. BY REGISTRAR
DEC 11 1986 | |
| | | 25b. REGISTRAR'S SIGNATURE
<u>John Davidson-Randall</u> | | | |

BP

05-11-12-12

05-11-12-12

05-11-12-12

05-11-12-12



026783 DEC 11 1986

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 3 4 9 1 1

REG. NO.

| | | | | | | | | | |
|--|--|-------------------------------------|---|---|---|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Charles H Sanders | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12-3-86 | | | 2b. HOUR
125 P.M. | | | |
| 3. SEX
Male | | 4. RACE
B. | | 5. DATE OF BIRTH
MONTH DAY YEAR
13 16 34 | | | 6. AGE (IN YEARS LAST BIRTHDAY)
52 YRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
N.C. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Liberty Medical Center | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
laborer | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
MD | | | 13b. COUNTY
Baltimore | | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS / ZIP CODE
1428 W. Baltimore St. 21223 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Ott Sanders | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Anne Goin | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
239-48-7384 | | | 17. INFORMANT
Alberta Sanders 233 Douglas St 21231 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a), 1b), and 1c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
b) <u>Large Cell CA of Lung (R)</u>
DUE TO, OR AS A CONSEQUENCE OF
c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/26</u> 19 <u>86</u> to <u>12/3</u> 19 <u>86</u> that (I) (we) last saw the deceased alive on <u>12/3</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Eleanor Y. Hixon MD | | | | | | DEGREE
MD | | 22c. DATE SIGNED
12/3/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Eleanor Y. Hixon MD | | | | | | 22e. ADDRESS
601 Broadway Suite 201 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | | 23b. DATE
12-10-86 | | 23c. NAME OF CEMETERY OR CREMATORY
MT. ZION | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
LANDSDOWN MD | | |
| 24. FUNERAL DIRECTOR
NAME
MARCH FUNERAL HOME | | | | | | ADDRESS
1101 E. NORTH AVE. | | 25. DATE REC'D. BY REGISTRAR
DEC 9 1986 | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE
Julia Smith | | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the permit pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

7 MONTHS - 8

WINTER - 2ND



05058 1 012

027289 DEC 16 1986

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|--|---|---|--|--|-----------------------------------|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
JAMES T. SANDERS | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12-8-86 | | 2b. HOUR
4:08 PM | | | | |
| 3. SEX
MALE | | 4. RACE
BLACK | | 5. DATE OF BIRTH
MONTH DAY YEAR
8 29 38 | | 6. AGE (IN YEARS LAST BIRTHDAY)
48 YRS
IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY, MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
BON SECOURS HOSPITAL | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
N/A | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
Maryland | | | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Charles Sanders | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Bessie Brumskill | | | | 13e. STREET ADDRESS / ZIP CODE
2015 Penrose Avenue 21223 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES NO OR UNKNOWN)
YES | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
213-32-9953 | | 17. INFORMANT
ADDRESS
Bessie Sanders 2015 Penrose Avenue | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) septic shock
DUE TO, OR AS A CONSEQUENCE OF (b) Ext Arterial Dissection
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a
acute & congested varices with bleeding | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/3 19 86 to 12/8 19 86 , that (I) (we) last saw the deceased alive on 12/8 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)
J. BELTRAN | | | | 22c. DATE SIGNED
12/19/86 | | 22d. ADDRESS
1940 W. BALTIMORE ST, BALTO MD 21223 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
12/13/86 | | 23c. NAME OF CEMETERY OR CREMATORY
Garrison Forest VA | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Owings Mills, Md. | | | |
| 24. FUNERAL DIRECTOR
NAME
March Funeral Homes | | | | 25a. DIED IN U.S. DEPARTMENT OF HEALTH AND MENTAL HYGIENE
ADDRESS
1101 East North Avenue | | 25b. REGISTRAR'S SIGNATURE
Julia Sanders-Randall | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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PAK EX 11111 11111

20% POLLO 11111

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | | | | |
|---|---------|--|--|---|--|---|--|---|--|--------------------------|--|---|--|----------|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH | | | | 2b. HOUR | | | | | |
| Alma | | | | | | Sanford | | <input checked="" type="checkbox"/> MONTH DAY YEAR
12/31/1986 | | | | <input type="checkbox"/> 12/31/1986 | | | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | | | 7d. HOUR | | | |
| F | B | 8 13 16 | | 70 YRS. | | MONTHS DAYS HOURS MIN. | | | | 12/ 31/19 86 | | | | 2:13 P M | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | NEVER MARRIED | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | |
| VA | | USA | | WIDOWED | | DIVORCED | | Baltimore City, | | | | MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | |
| Baltimore | | Johns Hopkins Hospital | | HOUSEWIFE | | | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | | | | | |
| MD | | | | BALTO. | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 914 N. KENWOOD AVE. | | 21205 | | | | | | | |
| 14. FATHER'S NAME | | MIDDLE | | LAST | | 15. MOTHER'S MAIDEN NAME | | MIDDLE | | LAST | | | | | | | |
| ALEXANDER | | | | RAGLAND | | LAURA | | | | TUCKER | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | | | | | |
| NO | | 21720 8216 | | HERBERT DIXON | | 914 N. KENWOOD AVE. | | 21205 | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying cause last</u> . | | | | | | | | | | | | | | | | | |
| (b) _____ | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | |
| (c) _____ | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. | | | | | | | | | | | | | | | | | |
| <u>Obesity</u> | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? | | | | | |
| | | | | | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | |
| | | | | P.M. 19 | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| | | | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | TITLE (SPECIFY) | | | | DATE SIGNED | | | | | | | | | |
| <i>Ann M. Dixon</i> | | | | M.D. Assistant | | | | MEDICAL EXAMINER | | | | 1/1/87 | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS | | | | | | | | | | | | | |
| Ann M. Dixon, M.D. | | | | 111 Penn St. | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION CITY COUNTY MD. | | | | | |
| BURIAL | | | | 1/6/87 | | | | BALTIMORE CEMETERY | | | | BALTIMORE, COUNTY MD. | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| MARCH FUNERAL HOME 1101 E. NORTH AVE. | | | | | | | | JAN 5 1987 | | | | | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXCUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXCISE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSFER PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201. PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))



100% COTTON FIBER

MADE IN U.S.A.



027891

DEC 23 1986

FOR
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|--|--|---|---|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Margaret M. Sanford | | | 2a. DATE OF DEATH
MONTH DAY YEAR
December 20, 1986 | | | 2b. HOUR
M
AM | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
October 21, 1920 | | 6. AGE (IN YEARS LAST BIRTHDAY)
66 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
66 | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
1557 E. Northern Pkwy. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Rental Agent-Wallace H. Campbell | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
1557 E. Northern Pkwy. 21239 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
George Stuck | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Rosa F. Owings | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
212-14-3593 | | 17. INFORMANT
ADDRESS
Bruce Baynard 1810 Portship Road 21222 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
DUE TO, OR AS A CONSEQUENCE OF (c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Walter B. Koppel | | | | | | DEGREE
MD | | 22c. DATE SIGNED
12/22/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Dr. Walter B. Koppel M.D. | | | | | | 22e. ADDRESS
1900 E. Northern Pkwy. Baltimore, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | | 23b. DATE
12-23-86 | | 23c. NAME OF CEMETERY OR CREMATORY
Westview | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Maryland | | |
| 24. FUNERAL DIRECTOR
NAME
Duda-Ruck, Inc.
ADDRESS
7922 Wise Avenue Baltimore, Md. 21222 | | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 22 1986 | | 25b. REGISTRAR'S SIGNATURE | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be placed in the box provided within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

BP

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027416 DEC 17 1986

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|---|---|--|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
EDWARD William SANN | | | 2a. DATE OF DEATH
MONTH DAY YEAR
DECEMBER 15, 1986 | | 2b. HOUR
1:20am |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
4 19 09 | 6. AGE (IN YEARS LAST BIRTHDAY)
77
YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Church Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | | 12b. KIND OF BUSINESS OR INDUSTRY
Armco Steel |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | 13b. COUNTY
Baltimore | 13c. CITY OR TOWN
Baltimore | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Jacob Sann | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Wilsehanna | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
W.W. 2 213-07-8944 | | 17. INFORMANT
ADDRESS
Myrtle A. Sann 431 S. Robinson St. 21224 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) LUNG CANCER
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from DECEMBER 10, 1986 , to DECEMBER 15, 1986 , that (I) <input checked="" type="checkbox"/> we <input type="checkbox"/> saw the deceased alive on DECEMBER 15, 1986 , and that in (my) <input checked="" type="checkbox"/> our opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> we <input type="checkbox"/> did not view the body after death. | | | | | |
| 22b. SIGNATURE
[Signature]
22b. PHYSICIAN'S NAME (TYPE OR PRINT)
Dr. J. Hodges | | | | 22c. DATE SIGNED
12/15/86 | |
| 22b. ADDRESS
CHURCH HOSPITAL CORPORATION
100 N. BROADWAY BALTIMORE, MD. 21231 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
12-18-86 | | 23c. NAME OF CEMETERY OR CREMATORY
Sacred Heart of Jesus | |
| 24. FUNERAL DIRECTOR
NAME
Charles S. Zeiler & Son Inc. | | ADDRESS
901 S. Conkling St. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Dundalk, Balto. Co., Md. | |
| 25a. DATE REC'D. BY REGISTRAR
DEC 16 1986 | | | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

0574 11 1550

Handwritten notes and diagrams on lined paper, including the word "Cotton" written vertically and various scribbles and markings.

Handwritten notes at the bottom of the page, including the number "1-1" and other illegible markings.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | |
|--|--|--|--|---|--|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) NICHOLAS NMN SANSONE | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12/19/86 | | 2b. HOUR
1155 M | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
March 24, 1910 | | 6. AGE (IN YEARS LAST BIRTHDAY)
76 YRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE CITY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
ST. AGNES HOSPITAL | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Driller | | 12b. KIND OF BUSINESS OR INDUSTRY
Bethlehem Steel | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE Maryland 13b. COUNTY Baltimore 13c. CITY OR TOWN Catonsville | | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
500 Durango Road 21228 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John Sansone | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Maria Sansone | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
218-09-7039 | | 17. INFORMANT
ADDRESS
Dorothy Sansone Same as # 13 | | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **COMA**

DUE TO, OR AS A CONSEQUENCE OF

(b) **CEREBROVASCULAR ACCIDENT**

DUE TO, OR AS A CONSEQUENCE OF

(c) **CARDIOGENIC SHOCK**APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

MYOCARDIAL INFARCT

MEDICAL CERTIFICATION

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____. that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
M. Shortall | | | | DEGREE | | 22c. DATE SIGNED
12/19/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
M. SHORTALL | | | | 22e. ADDRESS
ST AGNES HOSPITAL
400 Catonsville Avenue Catonsville MD. | | | |

| | | | | | | | |
|---|--|------------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
12/22/86 | | 23c. NAME OF CEMETERY OR CREMATORY
Holy Cross Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Brooklyn Maryland | |
| 24. FUNERAL DIRECTOR
Leroy M. & Russell C. Witzke | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 22 1986 | | 25b. REGISTRAR'S SIGNATURE
Julia Borden-Rodgers | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1, 2, and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

028377
377 DEC 29 86

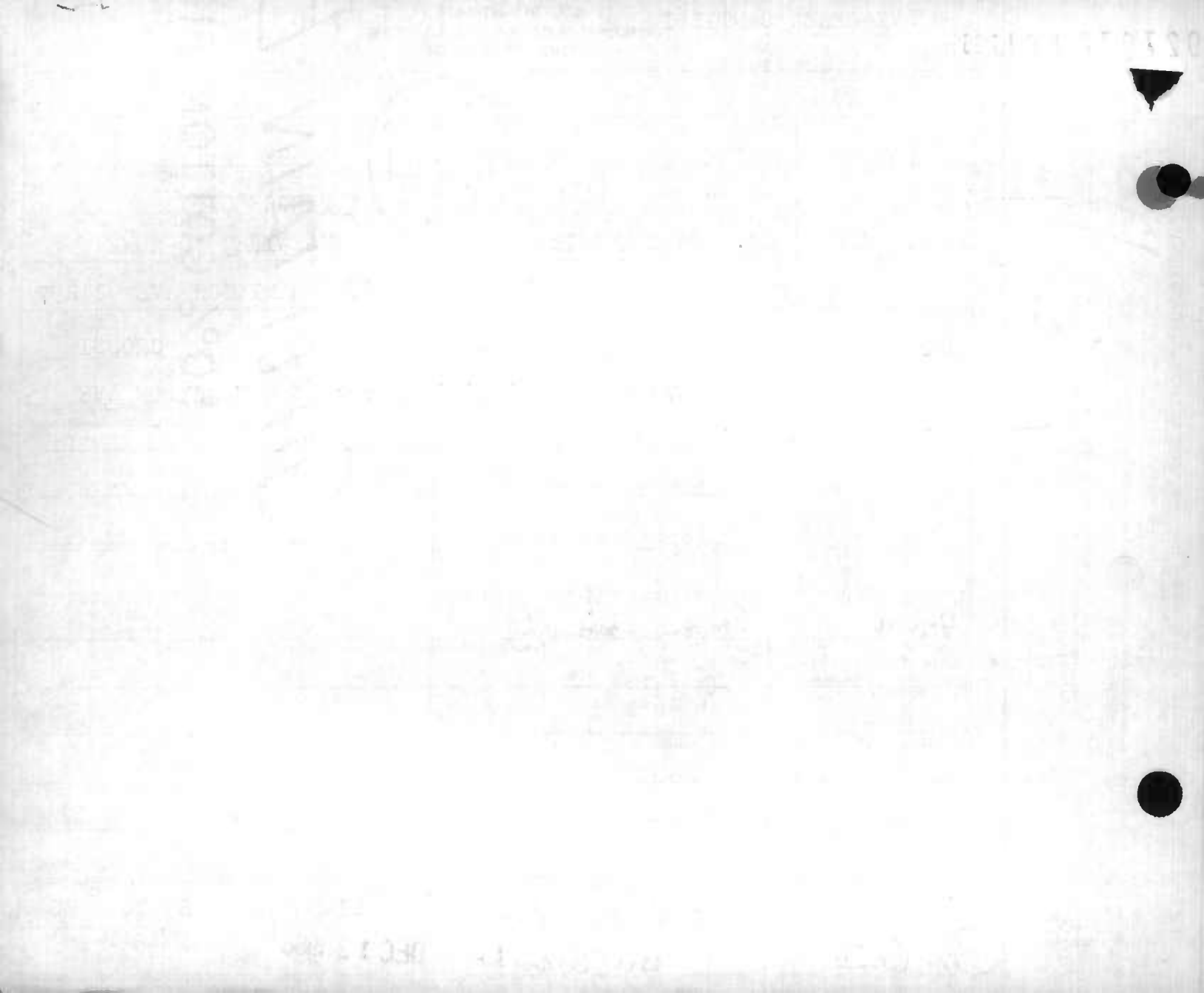
TO HOSPITAL OF ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill it in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon paper (page 1) and file it with 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medication should be notified at once.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
VINCENTZA | | LAST
SANTILLI | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 10 86 | | 2b. HOUR
2306 M | |
| 3. SEX
F FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
02 24 1904 | | 6. AGE (IN YEARS LAST BIRTHDAY)
82 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
ITALY | | 7b. CITIZEN OF WHAT COUNTRY?
ITALY | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD | |
| 10. CITY OR TOWN OF DEATH
BALTO CITY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(NOT IN SUCH FACILITY GIVE STREET ADDRESS)
ST. AGNES HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY
HOME | |
| 13a. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 13b. STREET ADDRESS
6005 HAMILTON AVE 21237 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
NATIA | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ANNA GROSSI | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
n/a | | 17. INFORMANT ADDRESS
Virginia Rocca 6005 HAMILTON AVE | | | |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
(a) IMMEDIATE CAUSE (a) SEPSIS
(b) DUE TO, OR AS A CONSEQUENCE OF
(b) BILATIAL ABSCESSES
(c) DUE TO, OR AS A CONSEQUENCE OF
(c) GONORRHOEA CIRCULOCITITIS
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
12 HRS
1 DAY
2 DAYS | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a. | | | | | | | |
| 19a. DATE OF OPERATION
12-10-86 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Gastric Cholecystectomy | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (this hospital) attended the deceased from 12/10/86 to 12/10/86, that (I) (we) last saw the deceased alive on 12/10/86, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Steven H. Pearlman | | | | DEGREE
M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
12/15/86 | |
| 23a. PHYSICIAN'S NAME (TYPE OR PRINT)
STEVEN H. PEARLMAN | | | | 23b. ADDRESS
ST. AGNES HOSPITAL 500 J. CATTON AVE | | | |
| 23a. BURIAL, CREMATION, REMOVAL
ENTOMB | | 23b. DATE
12/15/86 | | 23c. NAME OF CEMETERY OR CREMATORY
DULANEY VALLEY | | 23d. LOCATION
TIMONIUM BALTO MD | |
| 24. FUNERAL DIRECTOR
C. J. ... | | ADDRESS
... .. | | 25a. DATE REC'D BY REG. CLERK
DEC 12 1986 | | 25b. REGISTRATION SIGNATURE
... .. | |

BP.



029260 JAN - 3 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | |
|--|--|---|--|---|---|---|---------------------------------------|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
RONALD SATTERFIELD | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12/28/86 | | | 2b. HOUR
12:15A | | | | |
| 3. SEX
Male | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
8/ 14/ 51 | | 6. AGE (IN YEARS LAST BIRTHDAY)
35 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
IF UNDER 24 HRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Baltimore | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
JOHN'S HOPKINS HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Amtrak crane op. | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Baltimore | | | | | 13b. COUNTY
Maryland | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Glennie Satterfield | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Gertie Thomas | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES OR NO) no | | | 16b. SOCIAL SECURITY NO.
215-52-3930 | | | 17. INFORMANT
ADDRESS
Donald Satterfield 2802 Belmont ave | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory Arrest
DUE TO, OR AS A CONSEQUENCE OF:
(b) Septic Shock
DUE TO, OR AS A CONSEQUENCE OF:
(c) Pneumonia | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
5 minutes
18 hours
7 days | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
Acquired Immune Deficiency Syndrome (AIDS) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Dec 23 19 86 , to Dec 28 19 86 , that (I) (we) last saw the deceased alive on Dec 28 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Elia V Barr MD | | | | | | DEGREE
MD | | 22c. DATE SIGNED
12/28/86 | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ELIA V BARR MD | | | | | | 22e. ADDRESS
DR's lounge, Tower 10, JHH, Baltimore, 21205 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
1/2/87 | | 23c. NAME OF CEMETERY OR CREMATORY
King Park Cem. | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Ranallstown | | |
| 24. FUNERAL DIRECTOR
NAME
W.C. March F.H. 4300 Wabash Ave. | | | | | | 25a. DATE REC'D BY REGISTRAR
DEC 31 1986 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | |

MEDICAL CERTIFICATION

29

BP

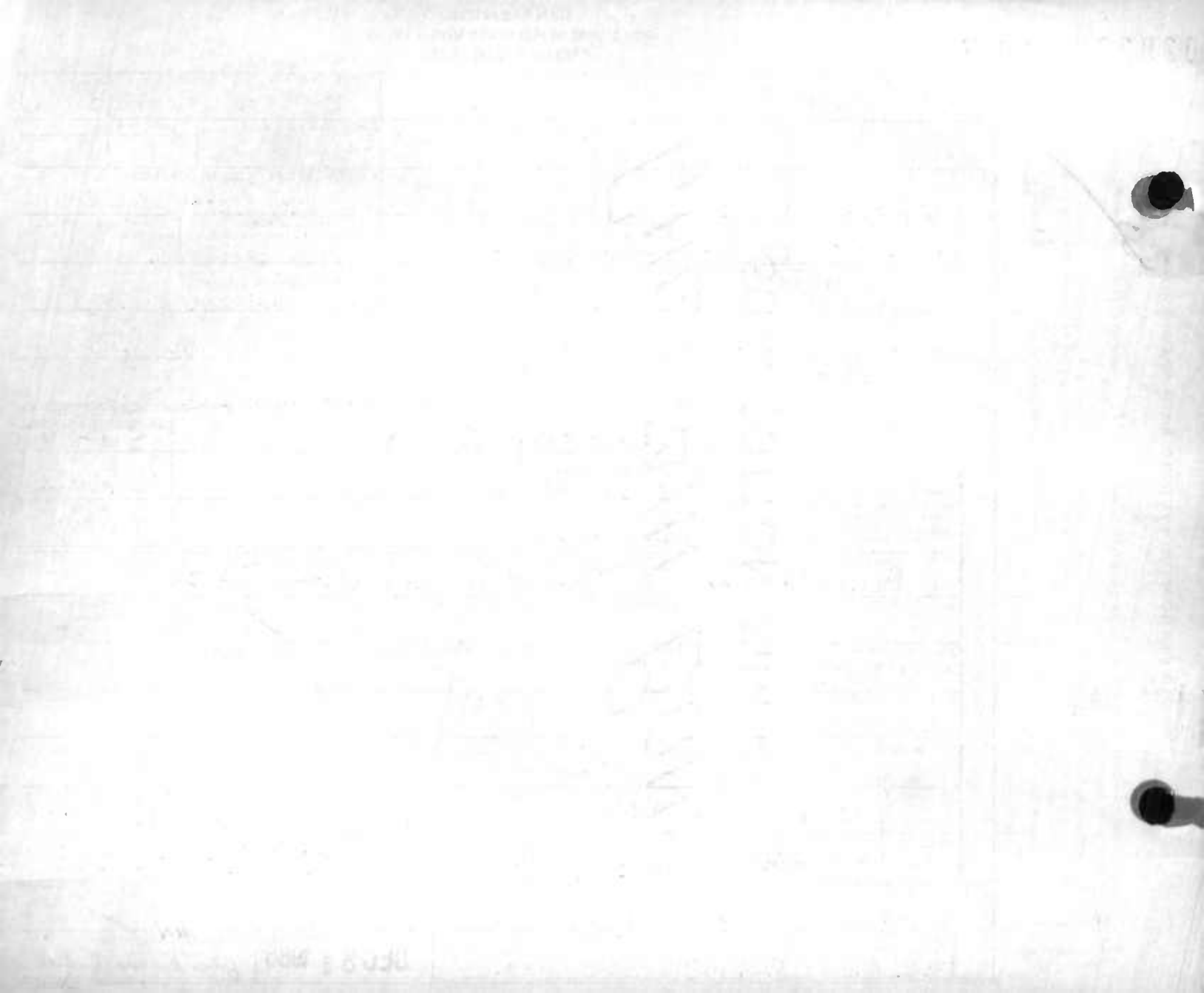
DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be reported at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201



026347 DEC

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6 3 4 9 1 9

| | | | | | | | | | | | | | |
|---|--|--|--|---|-------------------------|--------------------------------------|--|---|--|--|--|----------------------------|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | | | |
| 1a. DECEASED NAME (TYPE OR PRINT) | | | | | 2a. DATE KNOWN OF DEATH | | | | | 2b. HOUR | | | |
| Benjamin Saunders | | | | | 12/1/ 19 86 | | | | | M | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | 7. IF UNDER 1 YR. | | 7. IF UNDER 24 HRS. | | | |
| M | | B | | 2 24 54 | | 32 YRS. | | MONTHS DAYS HOURS MIN | | 2c. DATE PRONOUNCED DEAD | | | |
| 1a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | 12b. KIND OF BUSINESS OR INDUSTRY | | 24 HOUR | | | |
| MD | | USA | | WIDOWED NEVER MARRIED DIVORCED | | Baltimore City, MD | | | | 6:08 A M | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| Baltimore | | 918 E. Biddle St. | | N/A | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | |
| Md | | | | BALTO. | | YES NO | | 912 E. BIDDLE ST. 21202 | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | |
| AARON SAUNDERS | | THELMA FITZGERALD | | NO | | 220640223 | | SHARON SAUNDERS | | APT. 1310 221 N. FREEMONT AV | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Alcoholism with Fatty Cirrhosis | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? | | | |
| | | | | | | | | | | YES NO | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH | | | | 21b. TIME OF INJURY | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| | | | | HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK OR NOT WHILE AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION | | | | | |
| | | | | | | | | CITY OR TOWN COUNTY STATE | | | | | |
| 22. I certify that I took charge of the remains described above, held on Autopsy Inspection Inquiry and in my opinion death resulted from: Natural causes Accident Suicide Homicide Undetermined manner | | | | | | | | | | | | | |
| TITLE (SPECIFY) | | | | | | | | | | | | | |
| M.D. Assistant MEDICAL EXAMINER | | | | | | | | | | | | | |
| DATE SIGNED 12/1/86 | | | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Gregory R. Kauffman, M.D. ADDRESS 111 Penn St. | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION | | | |
| BURIAL | | | | 12-8-86 | | MT. ZION CEMETERY | | | | LANSDOWNE MD | | | |
| 24. FUNERAL DIRECTOR NAME | | | | | | 25a. DATE REC'D. BY REGISTRAR | | | | | | 25b. REGISTRAR'S SIGNATURE | |
| MARCH FUNERAL HOME 1101 E. NORTH AVE | | | | | | DEC 5 1986 | | | | | | Division Records | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE WITHIN 72 HOURS. THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

100-31516380

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 3 4 9 2 0

FOR
 1- STATE
 REGISTRAR

REG. NO.

028024 DEC 23 1986

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME
FIRST MIDDLE LAST
<i>Leopold William Saunders</i> | | | 2a. DATE OF DEATH
MONTH DAY YEAR
<i>12 15 86</i> | | | 2b. HOUR
<i>8 PM</i> | |
| 3. SEX
<i>Male</i> | | 4. RACE
<i>Black</i> | | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>6-1-1915</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>71</i> YRS. | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>Md</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Baltimore City, MD.</i> | |
| 10. CITY OR TOWN OF DEATH
<i>Baltimore</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE RESIDENCE BEFORE ADMISSION)
<i>Villa St. Michaels Nursing Home</i> | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Meat Cutter</i> | |
| 12b. KIND OF BUSINESS OR INDUSTRY
<i>S.W. Tr. Co.</i> | | 13a. STATE
<i>Md</i> | | 13b. COUNTY
<i>Balto.</i> | | 13c. CITY OR TOWN
<i>Oella</i> | |
| 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
<i>315 Oella Ave. 21228</i> | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>No</i> | | 16b. SOCIAL SECURITY NO.
<i>219-03-4294</i> | | 17. INFORMANT
ADDRESS
<i>Zola Saunders 315 Oella Ave 21228</i> | | | |

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
 PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) *MALIGNANT ASTROCYTOMA*

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
 gave rise to immediate
 cause (a), stating the
 underlying cause last

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
 BETWEEN ONSET AND DEATH

3 months

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<i>11-25 1986</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
<i>7220 Park Heights Ave 21208</i> | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>11-25</i> , 19 <i>86</i> , to <i>12-15</i> , 19 <i>86</i> that (I) (we) last saw the deceased alive on <i>12-5</i> , 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<i>Harold B. Bob</i> | | | | DEGREE
<i>MD</i> | | 22c. DATE SIGNED
<i>12-16-86</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>Harold B. Bob</i> | | | | 22e. ADDRESS
<i>7220 Park Heights Ave 21208</i> | | | |

| | | | | | | | |
|--|--|--------------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<i>Cremation</i> | | 23b. DATE
<i>18 Dec. 86</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Westview Mem. PK.</i> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Catonsville Balto. Md.</i> | |
| 24. FUNERAL DIRECTOR
NAME
<i>Slack Funeral Home</i> | | | | ADDRESS
<i>Box 268 Ellicott City, Md. 21043</i> | | 25a. DATE REC'D. BY REGISTRAR
<i>DEC 19 1986</i> | |
| | | | | 25b. REGISTRAR'S SIGNATURE
<i>Julia London</i> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it is to be filed with the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 are to be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the Medical Examiner must be notified.

1030

NOTICE TO COLLECTOR



Handwritten notes or signatures in the middle right margin.

Handwritten mark or signature at the bottom right.

027603 DEC 19 86

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

5634921

| | | | | | |
|--|--|---|--|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT) Baby GIRL SCALES | | | 2a. DATE OF DEATH
MONTH DAY YEAR
Nov 10 1986 | | 2b. HOUR
8:05 P.M. |
| 3. SEX
FEMALE | 4. RACE
NEGRO | 5. DATE OF BIRTH
MONTH DAY YEAR
Oct 30 1986 | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS. MONTHS DAYS
11 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
St. Agnes Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
N/A | | 12b. KIND OF BUSINESS OR INDUSTRY
N/A |
| 13a. STATE
Maryland | | | 13b. COUNTY
Baltimore | 13c. CITY OR TOWN
Baltimore | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
unknown | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Chennis Scales | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | 16b. SOCIAL SECURITY NO.
N/A | | 17. INFORMANT
ADDRESS
Chennis Scales Same as # 13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) RESPIRATORY INSUFFICIENCY
DUE TO, OR AS A CONSEQUENCE OF (b) CARDIAC FAILURE
DUE TO, OR AS A CONSEQUENCE OF (c) DELETION - SHORT ARM Chromosome #4 | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED
(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (this hospital) attended the deceased from Oct. 30 , 19 86 , to Nov 10 , 19 86 , that (we) lost
saw the deceased alive on Nov 30 , 19 86 , and that in (my) own opinion death occurred on the date and hour and from the causes stated
above, (I) do (did) not view the body after death. | | | | | |
| 22b. SIGNATURE
Ben J Morton | | DEGREE
M.D. | | 22c. DATE SIGNED
Nov 11, 1986 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MORTON | | 22e. ADDRESS
St. Agnes Hospital Baltimore, MD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) BURIAL | | 23b. DATE
12/15/86 | | 23c. NAME OF CEMETERY OR CREMATORY
NEW CATHEDRAL | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE MD. 21229 | | | | | |
| 24. FUNERAL DIRECTOR
NAME
WITZKE F. HOME | | 1630 Edmondson Avenue
BALTO., MD. 21228 | | 25a. DATE REC'D BY REGISTRAR
DEC 18 1986 | |
| | | 25b. REGISTRAR'S SIGNATURE
<i>Julia Gordon-Landolt</i> | | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please complete the following: Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|--|--|--|--|---|--|--|---|--|---|----------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Marie Rose Schaller | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
December 8, 1986 | | | 2b. HOUR
520 P.M. | | | |
| 3. SEX
female | | 4. RACE
white | | 5. DATE OF BIRTH
MONTH DAY YEAR
July 25 1925 | | 6. AGE (IN YEARS LAST BIRTHDAY)
61 YRS | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Union Memorial Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Bookkeeper | | 12b. KIND OF BUSINESS OR INDUSTRY
Florist | | | |
| 13a. STATE
Md. | | | | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Frank Wielepski | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Stella Washeski | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
no | | | | | 16b. SOCIAL SECURITY NO.
216-18-6039 | | 17. INFORMANT
ADDRESS
Martin Schaller Jr. (son) 7070 Skyles Way
Springfield Va | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Respiratory Failure</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>COPD + CHF</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
22151 | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
<u>HTN, metastatic Breast Ca, IDDM, Graves Disease.</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION
Ø | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Ø | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)
21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK OR WHILE <input type="checkbox"/> AT WORK | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. Ø 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
Ø | | | | | | | |
| 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
Ø | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
Ø | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/5</u> 19 <u>86</u> , to <u>12/8</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>12/8</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Jeffrey A. Grass, M.D.</u> | | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED
12/8/86 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Jeffrey A. Grass, M.D. | | | | | 22e. ADDRESS
Union Memorial Hospital | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
12/11/86 | | 23c. NAME OF CEMETERY OR CREMATORY
HOLY REDEEMER | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE MD. | | | | | |
| 24. FUNERAL DIRECTOR
SCHIMONEK FUNERAL HOME, INC.
9705 Belair Rd., Balto. Md. 21236 | | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 11 1986 | | 25b. REGISTRAR'S SIGNATURE
<u>Lia Davidson-Randall</u> | | | |

10-1-1944

3

Handwritten notes and calculations, including a table with columns labeled 'A', 'B', 'C', 'D', 'E', 'F', 'G', 'H', 'I', 'J', 'K', 'L', 'M', 'N', 'O', 'P', 'Q', 'R', 'S', 'T', 'U', 'V', 'W', 'X', 'Y', 'Z'. The table contains numerical data and some text entries.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR
1-86 | | 2a. DATE OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
Alwin C. SCHNEIDER | | 12 02 86 | | 2:10 A.M. | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
June 23 94 | | 6. AGE (IN YEARS LAST BIRTHDAY)
92 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Mercy Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Minister | | 12b. KIND OF BUSINESS OR INDUSTRY
Church | |
| 13a. STATE
Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Carl Schneider | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Minnie Mentl | | 13e. STREET ADDRESS / ZIP CODE
3143 Strickland Street, 21229 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
--- 216-36-3531 | | 17. INFORMANT
Louis Schneider, 61 Algonquin Road, 21901 | | ADDRESS | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiac arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Bowel Perforation</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Aspiration Pneumonia</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/15</u> , 19 <u>86</u> , to <u>12/2</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>12/2</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>Keith E. Friend</u> | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>Keith E. Friend</u> | | | | 22e. ADDRESS
Mercy Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
12/5/86 | | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Maryland | |
| 24. FUNERAL DIRECTOR
NAME
Hubbard Funeral Home, Inc., 4107 Wilkens Ave. | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 3 1986 | | 25b. REGISTRAR'S SIGNATURE
<u>Julia Gordon-Rader</u> | |

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|---|--|--------------------|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) <i>Cecile</i> FIRST MIDDLE LAST <i>Schoerner</i> | | | 2a. DATE OF DEATH MONTH DAY YEAR <i>December 31, 1986</i> | | 2b. HOUR M <i></i> | | |
| 3. SEX <i>Female</i> | | 4. RACE <i>Caucasian</i> | | 5. DATE OF BIRTH MONTH DAY YEAR <i>12 22 1912</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) <i>74</i> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN) <i>Mass</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD. | |
| 10. CITY OR TOWN OF DEATH <i>Baltimore</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <i>Church Hospital</i> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Homemaker</i> | | 12b. KIND OF BUSINESS OR INDUSTRY <i>Home</i> | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <i>Id</i> | | 13b. COUNTY <i>Baltimore</i> | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS / ZIP CODE <i>2100 Fleet St 21231</i> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>Flaven</i> | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Emillien Robischaud</i> | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i> | | 16b. SOCIAL SECURITY NO. <i>018-03-0693</i> | | 17. INFORMANT ADDRESS <i>Paul Schoerner 2100 Fleet St 21231</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Acute Pulm Edema</i> | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <i>Generalized Edema</i> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>12 30-86</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>12-31-86</i> to <i>12-31-86</i> , that (I) (we) last saw the deceased alive on <i>12-31-86</i> , and that (I) (our) opinion death occurred on the date and hour and from the causes stated above. | | | | | | | |
| 22b. SIGNATURE OF DEGREE <i>Theodore P. Nymk</i> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | | 22c. DATE SIGNED <i>1-2-87</i> |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>T. P. Nymk</i> | | 22e. ADDRESS <i>429 S Chesler St</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL <i>Burial</i> | | 23b. DATE <i>1-5-87</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Holly Hills</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore Co. Md</i> | |
| 24. FUNERAL DIRECTOR NAME <i>Rapmund L. Kozgar</i> ADDRESS <i>2525 Fleet St.</i> | | | | 25a. DATE REC'D. BY REGISTRAR <i>JAN 5 1987</i> | | 25b. REGISTRAR'S SIGNATURE <i>John Davidson-Rodgers</i> | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the funeral home. Then please remove carbon copies. Page 1 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked accident, traumatic injury, or other traumatic event, the medical examiner must be notified at once.

BP

027830 DE 123108

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH96 34925
REG. NO.

| | | | | | | | | | | | |
|---|--|---|--|---|--|--|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) WALTER Robert SCHOOLS | | | 2a. DATE OF DEATH
MONTH 12 DAY 18 YEAR 86 | | | 2b. HOUR
11:00AM | | | | | |
| 3. SEX
MALE | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH March DAY 6 YEAR 1912 | | 6. AGE (IN YEARS LAST BIRTHDAY)
75 74 YRS. | | IF UNDER 1 YEAR
MONTHS 7 DAYS 14 | | IF UNDER 24 HRS.
HOURS 11 MIN. 00 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNIVERSITY OF MARYLAND HOSP | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Ret CLERK | | | 12b. KIND OF BUSINESS OR INDUSTRY
Post office | | |
| 13a. STATE
MD | | | | 13b. COUNTY
AA. | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
104 FRANKLIN AVE 21225 | |
| 14. FATHER'S NAME
FIRST ROSSIER MIDDLE SCHOOLS LAST SCHOOLS | | | | 15. MOTHER'S MAIDEN NAME
FIRST ALICE MIDDLE MARTIN LAST MARTIN | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO.
None | | 17. INFORMANT
AUDREY SCHOOLS ADDRESS SAME AS #13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) INTRACTABLE VENTRICULAR TACHYCARDIA
DUE TO, OR AS A CONSEQUENCE OF
(b) CARDIOGENIC SHOCK
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c) MASSIVE MYOCARDIAL INFARCTION | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/7 19 86 , to 12/18 19 86 , that (I) (we) last saw the deceased alive on 12/18 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Thuy Nguyen | | | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
12/18/86 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
THUY NGUYEN | | | | | | 22e. ADDRESS
University of Maryland Hosp | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(IF ANY) BURIAL | | | 23b. DATE
12-22-86 | | 23c. NAME OF CEMETERY OR CREMATORY
Glen Haven Mem PK. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Glen Burnie A.A. MD. | | | | |
| 24. FUNERAL DIRECTOR
NAME McGully F.H. ADDRESS 237 E Patapsco Ave Balt. MD 21225 | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE
DEO 19 1986 | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit form. These pages are carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

2012-2013

03/10/2013

YTH

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1

BP

DHMM - 16 60M 7/84
(VRA 15, 4)

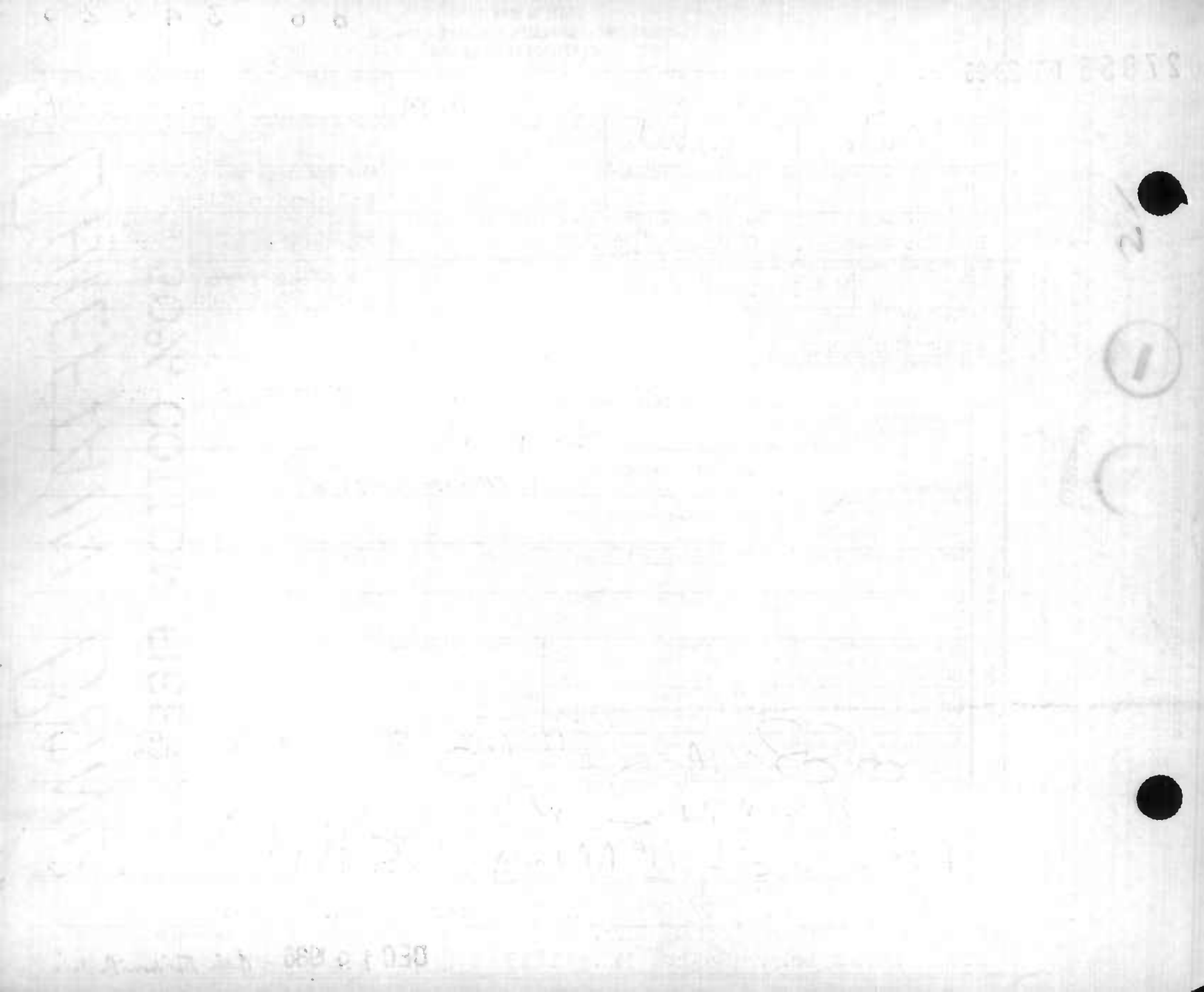
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical investigation conducted.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 6 3 4 9 2 6 | | | |
|--|---|---|--|--|---|---|--|
| 1- FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 2a DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
BERNARD C. SCHRAMM, SR. | | | | 2b DATE OF DEATH MONTH DAY YEAR
December 16 1986 | | 2c HOUR
6:10PM | |
| 3 SEX
Male | 4 RACE
White | 5 DATE OF BIRTH MONTH DAY YEAR
7/18/08 | | 6 AGE (IN YEARS LAST BIRTHDAY)
78 YRS. | 7 IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | 8 IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | 7b CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10 CITY OR TOWN OF DEATH
Balto. | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Church Hosp. Corp. | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Accountant | | 12b KIND OF BUSINESS OR INDUSTRY
Textile | | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b STATE 13c CITY OR TOWN
Md. Balto. Balto. | | | | 13d INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e STREET ADDRESS / ZIP CODE
8807 Dearborn Dr. 21236 | |
| 14 FATHER'S NAME FIRST MIDDLE LAST
Henry Schramm | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Anna Dietz | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | 16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)
- | | 17 INFORMANT ADDRESS
Anthony N. Schramm, son, same add. | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Sepsis</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pneumonia</u>
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
DECEMBER 7 | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a I certify that (1) this hospital attended the deceased from <u>DECEMBER 16</u> 19 <u>86</u> to <u>12-16</u> 19 <u>86</u> , that (1) (we) (we) saw the deceased alive on <u>DECEMBER 16</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (we) did not see the body after death. | | | | | | | |
| 22b SIGNATURE
<u>Dr. L. S. EL-Hennawy</u> | | DEGREE
<u>MD</u> | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c DATE SIGNED | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)
ADEL S. EL-HENNAWY | | 22e ADDRESS
CHURCH HOSPITAL CORPORATION
100 N. BROADWAY BALTIMORE, MD. 21231 | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b DATE
12/20/86 | | 23c NAME OF CEMETERY OR CREMATORY
Holy Redeemer | | 23d LOCATION CITY OR TOWN COUNTY STATE
Balto., Md. | |
| 24 Name of Funeral Home, Inc.
Sonamook Funeral Home, Inc.
3331 Brehms Lane, Balto., Md. 21213 | | | | 25a DATE REC'D. BY REGISTRAR
DEC 19 1986 | | 25b REGISTRAR'S SIGNATURE
<u>Julia Davidson-Burke</u> | |



028843 JAN 20

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 3 4 3 2 7

FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | |
|---|--|---|--|---|---|--|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Evelyn C. Schriener | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 - 27 - 86 | | | 2b. HOUR
11 ²⁵ P.M. | | | | |
| 3 SEX
Female | | 4 RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Nov. 19, 1928 | | 6 AGE (IN YEARS LAST BIRTHDAY)
58 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Mercy Hospital, Balto. Md. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker. | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | 13b. COUNTY
----- | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Howard ----- Talbott | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Media ----- Nelson | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | | 16b. SOCIAL SECURITY NO.
171-21-4383 | |
| 17 INFORMANT
21084
Darlene S. Kinniard | | | ADDRESS
Jarrettsville, Md.
3870 Calwyn Dr. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>progressive respiratory insufficiency</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>metastatic squamous cell carcinoma</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
2 days
2 months | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last
saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
M Beire MD | | | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
12/27/86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Melba Beire MD | | | | | 22e. ADDRESS
Mercy Hospital Baltimore, MD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
12/31/86 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto. A.A. Co. Md. | | | |
| 24. FUNERAL DIRECTOR
NAME
McCully Funeral Home, 130 E. Fort Ave. | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 30 1986 | | 25b. REGISTRAR'S SIGNATURE
J. A. Anderson-Randall | | | |

MEDICAL CERTIFICATION

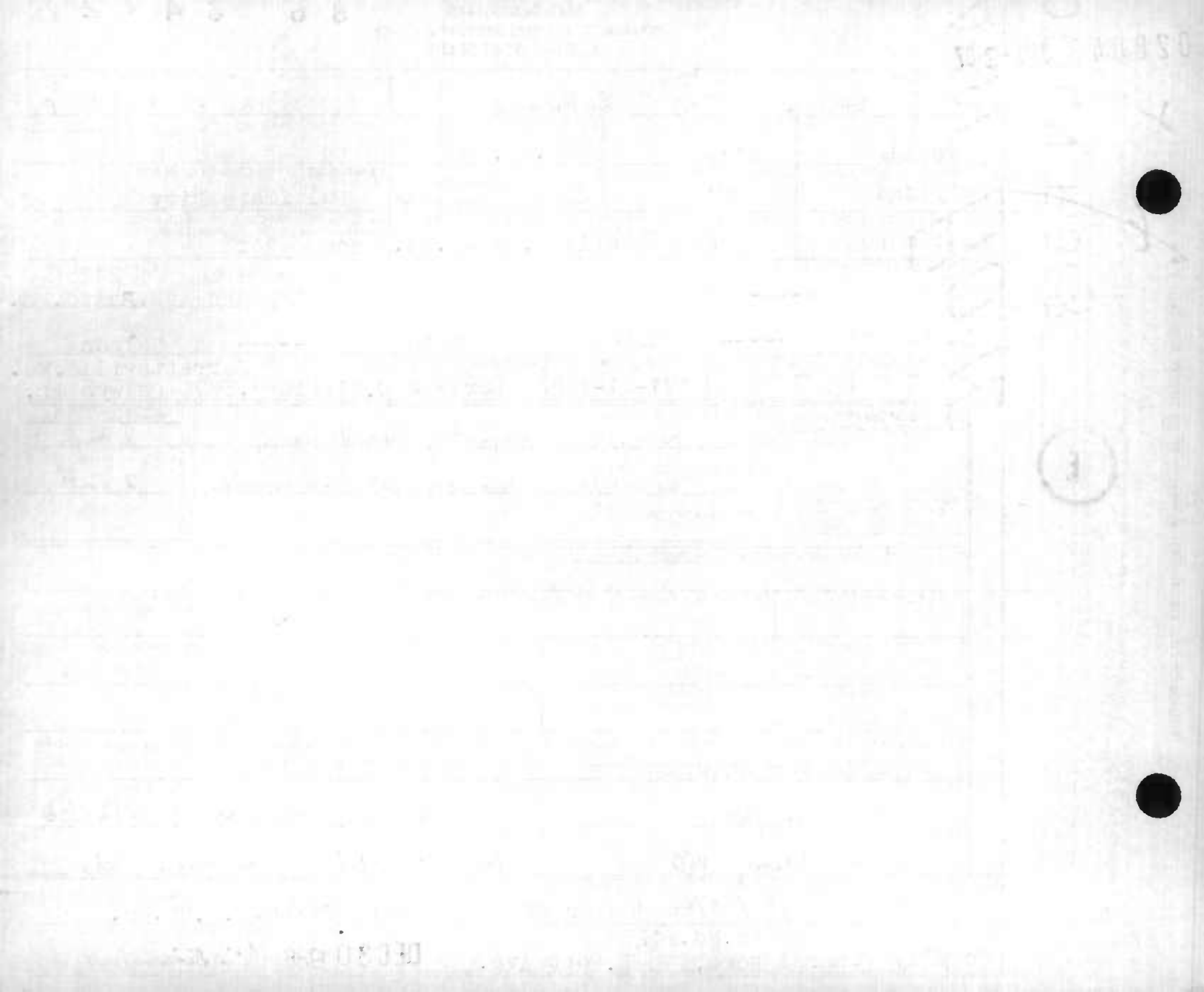
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please note the following instructions: Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other significant condition, the medical examiner must be notified at once.

BP



026564 DEC 10 1986

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | |
|---|--|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
Charlotte E. Schwaab | | 2a. DATE OF DEATH
MONTH 12 DAY 2 YEAR 86 HOUR 12 02 86 11 18 M | |
| 3. SEX
Female | 4. RACE
Caucasian | 5. DATE OF BIRTH
05-3-19 | 6. AGE
(IN YEARS LAST BIRTHDAY)
67 YRS. |
| 7a. BIRTHPLACE
(STATE OR FOREIGN)
Balt MD | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. |
| 10. CITY OR TOWN OF DEATH
Balt | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Umecc | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Inspector |
| 13a. STATE
MD | | 13b. COUNTY
Balt | 13c. CITY OR TOWN
Balt |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Joseph A Smith | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Marjorie Eckels | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
220 653688 | |
| 17. INFORMANT
Leroy Schwaab | | ADDRESS 21229
138 Stonecroft Rd | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Widely Metastatic Adenocarcinoma</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Adenocarcinoma of Uterus</u>
CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a
<u>Adenocarcinoma of Uterus</u> | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | |
| 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11 29</u> 19 <u>86</u> , to <u>12 02</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>12 02</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) visit the body after death. | | | |
| 22b. SIGNATURE
<u>Moheffan MD</u> | | 22c. DATE SIGNED
12 02 86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>MOHAMMED HASSAN</u> | | 22e. ADDRESS
22 S Green St. Balt MD | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
12-5-86 | 23c. NAME OF CEMETERY OR CREMATORY
Garrison Forest |
| 23d. LOCATION
Owings Mills, Balto., MD | | 24. FUNERAL DIRECTOR
NAME ADDRESS
MacNabb Funeral Home, Catonsville, MD | |
| 25a. DATE REC'D. BY REGISTRAR
DEC 8 1986 | | 25b. REGISTRAR'S SIGNATURE
<u>A. A. Anderson-Pudwell</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Page 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

856204 111028



OWINGE MILLER, BOSTON

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

| | | | | | |
|--|--|--|---|--|---|
| 1 DECEASED NAME
(TYPE OR PRINT)
FREDERICK C SCHWEITZER | | | 2a DATE OF DEATH
MONTH DAY YEAR
12 07 86 | | 2b HOUR
9:50 AM |
| 3 SEX
MALE | 4 RACE
WHITE | 5 DATE OF BIRTH
MONTH DAY YEAR
12 11 04 | 6 AGE (IN YEARS LAST BIRTHDAY)
81 YRS | IF UNDER 1 YEAR
MONTHS DAYS | IF UNDER 24 HRS
HOURS MIN. |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Baltimore, MD. | 7b CITIZEN OF WHAT COUNTRY?
U.S.A. | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH
CITY BALTIMORE MD. | | |
| 10 CITY OR TOWN OF DEATH
Baltimore | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
MERCY HOSPITAL | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Pressman | 12b KIND OF BUSINESS OR INDUSTRY
Reese Press | | |
| 13a STATE
MD. | | 13b COUNTY | 13c CITY OR TOWN
Baltimore | 13d INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
John Adam Schweitzer | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Anna | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | 16b SOCIAL SECURITY NO.
212-09-4096 | | 17 INFORMANT
Barbara M. Schweitzer = 3704 Elmley Ave. 21213 | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) METASTATIC SQUAMOUS CELL CARCINOMA YES
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
YES |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
OCCIPITAL LOBE STROKE | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2) | |
| 21d INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a I certify that (I) (this hospital) attended the deceased from DEC 1, 19 86, to DEC 7, 19 86, that (I) (we) last saw the deceased alive on DEC 7, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b SIGNATURE
Jonathan Aaron | | DEGREE
MD | | 22c DATE SIGNED
12/7/86 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)
JONATHAN AARON | | 22e ADDRESS
301 ST. PAUL ST, BALTO, MD 21209 | | | |
| 23a BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b DATE
12-11-86 | | 23c NAME OF CEMETERY OR CREMATORY
Gardens of Faith Cem. | |
| 23d LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Maryland | | | | | |
| 24 FUNERAL DIRECTOR
NAME
John C. Miller, Inc.-6415 Belair Road-21206 | | 25a DATE REC'D. BY REGISTRAR
DEC 9 1986 | | 25b REGISTRAR'S SIGNATURE
Julia Davidson-Randall | |

150231 10 10 12



29007 JAN -5

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

| | | | | | |
|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Bridget Scott | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 30 86 | | 2b. HOUR
10:00 A | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
06 25 12 | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
74 | | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Scotland | | 8. CITIZEN OF WHAT COUNTRY?
Scotland | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
4406 Falls Bridge Drive 21211 | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | | 13a. STREET ADDRESS / ZIP CODE
4406 Falls Bridge Dr. 21211 Apt. B | |
| 13a. STATE
Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Francis Molloy | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Doyle | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | |
| 16b. SOCIAL SECURITY NO.
057-30-9007 | | 17. INFORMANT
Robert Scott | | ADDRESS
4413 Falls Road 21211 | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) *Cardiac arrhythmia*

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

(b) *pneumonia*

DUE TO, OR AS A CONSEQUENCE OF

(c) *obstructing lung mass*

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
0 days

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

malnutrition, cachexia

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED
(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>July 25, 1986</i> to <i>December 30, 1986</i> that (we) last saw the deceased alive on <i>November 19, 1986</i> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<i>Mark Clinton</i> | | | | DEGREE
MD | | 22c. DATE SIGNED
12/30/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MARK CLINTON | | | | 22e. ADDRESS
Union Memorial Hospital | | | |

| | | | | | | | |
|---|--|-----------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | 23b. DATE
12/31/86 | | 23c. NAME OF CEMETERY OR CREMATORY
Green Mount Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Maryland | |
|---|--|-----------------------|--|--|--|--|--|

| | | | | | | | |
|--|--|-----------------------------------|--|--|--|---|--|
| 24. FUNERAL DIRECTOR
NAME
A. Alan Seitz, Jr. | | ADDRESS
3818 Roland Ave. 21211 | | 25a. DATE REC'D. BY REGISTRAR
DEC 31 1986 | | 25b. REGISTRAR'S SIGNATURE
<i>Julia Anderson-Randall</i> | |
|--|--|-----------------------------------|--|--|--|---|--|

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 4 and 5, and 7, and 8, and 9, and 10, and 11, and 12, and 13, and 14, and 15, and 16, and 17, and 18, and 19, and 20, and 21, and 22, and 23, and 24, and 25, and 26, and 27, and 28, and 29, and 30, and 31, and 32, and 33, and 34, and 35, and 36, and 37, and 38, and 39, and 40, and 41, and 42, and 43, and 44, and 45, and 46, and 47, and 48, and 49, and 50, and 51, and 52, and 53, and 54, and 55, and 56, and 57, and 58, and 59, and 60, and 61, and 62, and 63, and 64, and 65, and 66, and 67, and 68, and 69, and 70, and 71, and 72, and 73, and 74, and 75, and 76, and 77, and 78, and 79, and 80, and 81, and 82, and 83, and 84, and 85, and 86, and 87, and 88, and 89, and 90, and 91, and 92, and 93, and 94, and 95, and 96, and 97, and 98, and 99, and 100, and 101, and 102, and 103, and 104, and 105, and 106, and 107, and 108, and 109, and 110, and 111, and 112, and 113, and 114, and 115, and 116, and 117, and 118, and 119, and 120, and 121, and 122, and 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789, and 790, and 791, and 792, and 793, and 794, and 795, and 796, and 797, and 798, and 799, and 800, and 801, and 802, and 803, and 804, and 805, and 806, and 807, and 808, and 809, and 810, and 811, and 812, and 813, and 814, and 815, and 816, and 817, and 818, and 819, and 820, and 821, and 822, and 823, and 824, and 825, and 826, and 827, and 828, and 829, and 830, and 831, and 832, and 833, and 834, and 835, and 836, and 837, and 838, and 839, and 840, and 841, and 842, and 843, and 844, and 845, and 846, and 847, and 848, and 849, and 850, and 851, and 852, and 853, and 854, and 855, and 856, and 857, and 858, and 859, and 860, and 861, and 862, and 863, and 864, and 865, and 866, and 867, and 868, and 869, and 870, and 871, and 872, and 873, and 874, and 875, and 876, and 877, and 878, and 879, and 880, and 881, and 882, and 883, and 884, and 885, and 886, and 887, and 888, and 889, and 890, and 891, and 892, and 893, and 894, and 895, and 896, and 897, and 898, and 899, and 900, and 901, and 902, and 903, and 904, and 905, and 906, and 907, and 908, and 909, and 910, and 911, and 912, and 913, and 914, and 915, and 916, and 917, and 918, and 919, and 920, and 921, and 922, and 923, and 924, and 925, and 926, and 927, and 928, and 929, and 930, and 931, and 932, and 933, and 934, and 935, and 936, and 937, and 938, and 939, and 940, and 941, and 942, and 943, and 944, and 945, and 946, and 947, and 948, and 949, and 950, and 951, and 952, and 953, and 954, and 955, and 956, and 957, and 958, and 959, and 960, and 961, and 962, and 963, and 964, and 965, and 966, and 967, and 968, and 969, and 970, and 971, and 972, and 973, and 974, and 975, and 976, and 977, and 978, and 979, and 980, and 981, and 982, and 983, and 984, and 985, and 986, and 987, and 988, and 989, and 990, and 991, and 992, and 993, and 994, and 995, and 996, and 997, and 998, and 999, and 1000.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | | |
|--|-----------------|---|--|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST
Grace | | MIDDLE
Scott | | LAST
Scott | | 2a. DATE KNOWN OF ESTI. DEATH MATED <input checked="" type="checkbox"/> 12-20 19 86 | | 2b. HOUR
M | |
| 3. SEX
F | 4. RACE
Blk. | 5. DATE OF BIRTH
MONTH DAY YEAR
2/11/1915 | | 6. AGE (IN YEARS LAST BIRTHDAY)
71 YRS. | | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD
12-20 19 86 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
3217 Mondawmin Avenue | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
Md. | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
1937 2nd Ave | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
218-263248 | | 17. INFORMANT ADDRESS
Andrew Abrams 1937 2nd Ave | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cancer of Pancreas
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Arteriosclerotic Cardiovascular Disease | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE
<i>William M. Zane</i> | | TITLE (SPECIFY)
M.D. Assistant MEDICAL EXAMINER | | | | | | DATE SIGNED
12-21-86 | | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
William M. Zane, M.D. | | ADDRESS
111 Penn St., Balto., Md. 21201 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL | | 23b. DATE
1/5/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Vernon Chm. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Md. | | | | | |
| 24. FUNERAL DIRECTOR
NAME
<i>John H. Hall</i> | | ADDRESS
1712 N. North Ave | | 25a. DATE REC'D. BY REGISTRAR
JAN 8 1987 | | 25b. REGISTRAR'S SIGNATURE
<i>Julia Seaton-Randall</i> | | | | | |

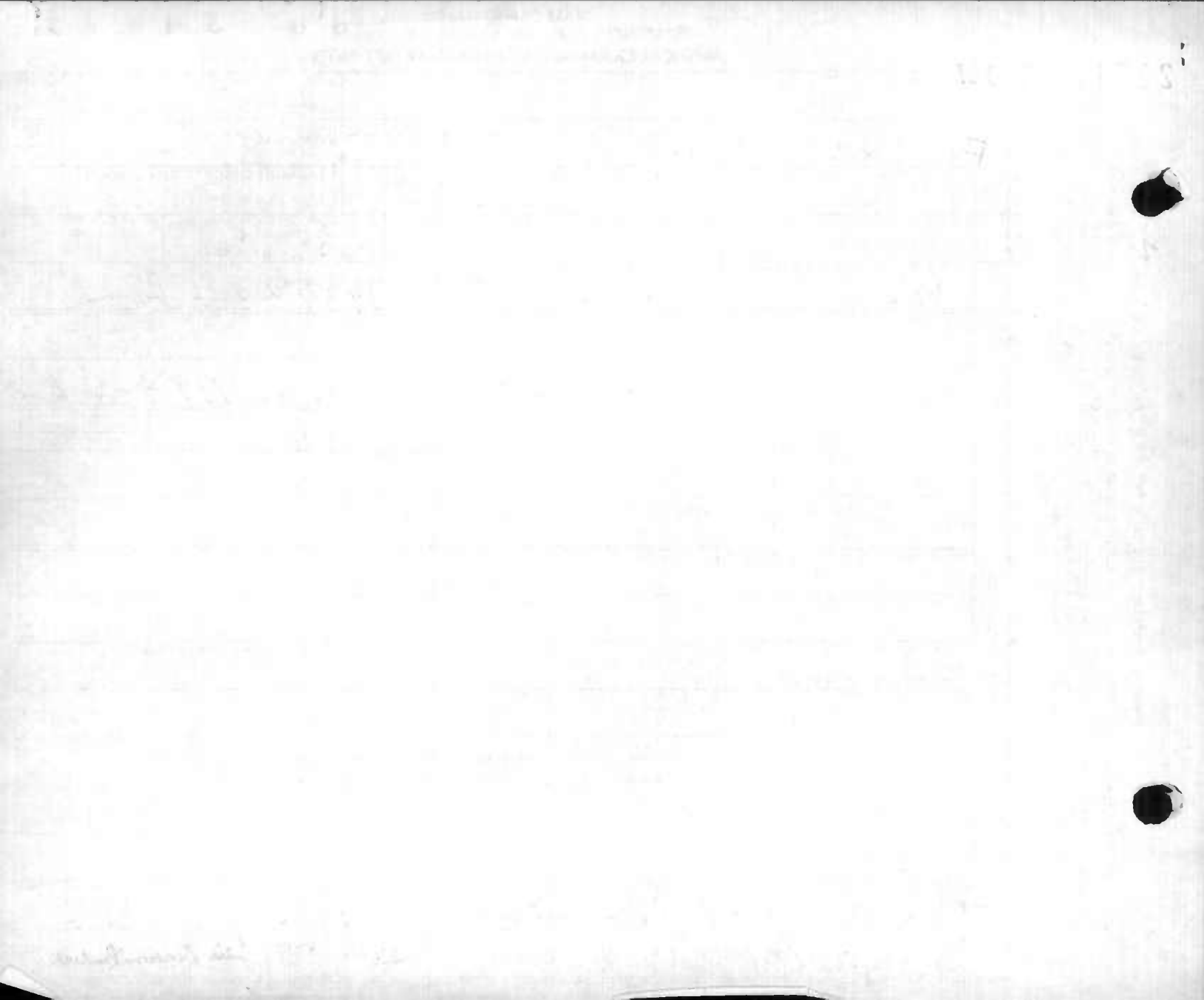
MEDICAL CERTIFICATION

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM TM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25M

BP
DHMH - 17
(VR A15 ME (5))



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the remaining pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other trauma, the medical examiner must be consulted about the cause of death.

BP

DHMH - 16 60M 7/B4
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 3 4 3 2

REG. NO.

| | | | | | | | | | | | |
|---|--|---|---|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) James C. Scott | | | 2a. DATE OF DEATH MONTH DAY YEAR 12 17 86 | | | 2b. HOUR 0228 AM | | | | | |
| 3. SEX M | | 4. RACE B | | 5. DATE OF BIRTH MONTH DAY YEAR 3 31 28 | | 6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kentucky | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY, MD. | | | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (If NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Loch Raven V.A. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unemployed | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE Maryland | | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 851 George Street Apt. 14K 21201 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | | 16b. SOCIAL SECURITY NO. 231-32-9485 | | 17. INFORMANT ADDRESS Daisy Scott 851 George Street Apt. 10K | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Sudden Cardiopulmonary arrest
DUE TO, OR AS A CONSEQUENCE OF (b) Infection
DUE TO, OR AS A CONSEQUENCE OF (c) Malnutrition
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) Malnutrition | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/16/86 , 19____, to 12/17/86 , 19____, that (I) (we) last saw the deceased alive on 12/17/86 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE ABASHER DEGREE | | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED 12/17/86 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ABASHER | | | | | 22e. ADDRESS 22. S. Greene St. Balt. MD | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION | | | 23b. DATE 12/18/86 | | 23c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md. | | | |
| 24. FUNERAL DIRECTOR NAME March Funeral Homes ADDRESS 1101 East North Avenue | | | | | 25a. DATE REC'D. BY REGISTRAR DEC 18 1986 | | | 25b. REGISTRAR'S SIGNATURE Julia Swanson-Rudolph | | | |

MEDICAL CERTIFICATION

055 1-25 1950

~~21~~

1

LOW PILES

DEC 18 1950

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAYS ARE NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. RETAIN PAGE 4 FOR THE CHIEF MEDICAL EXAMINER ALONG WITH FORM BA-3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

DHMH - 17
(VR A15 ME (5))

| STATE OF MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|---|--|---|--|--|--|---|--|----------------------------|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH | | 2b. HOUR | |
| ROD | | L. | | SCOTT | | | | DATE KNOWN OF DEATH | | HOUR | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | 7. DATE PRONOUNCED DEAD | | 8. HOUR | |
| Male | | Black | | 4/20/1949 | | 37 YRS. | | 12 17 19 86 | | 10 PM | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Va. | | U.S.A. | | MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | Baltimore City | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Baltimore | | Frederick Ave. & North Bend Rd. | | Laborer | | -----0---- | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | |
| Md. | | None | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 1303 Woodington Road 21229 | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | 17. ADDRESS | | | | | |
| (YES, NO, OR UNKNOWN) | | (IF YES, GIVE WAR OR DATES) | | 216-52-4050 | | Joan Scott, 1303 Woodington Rd 2122 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Multiple gunshot wounds (handgun) | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | | | | | | | |
| | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED | | | | | | | |
| | | HOUR MONTH DAY YEAR | | ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2 | | | | | | | |
| | | P.M. 12-17-19 86 | | Subject shot by police. | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | | | | | | | |
| | | street | | STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| | | | | Frederick Ave. & North Bend Rd. | | | | | | | |
| | | | | Balto. | | | | | | | |
| | | | | MD | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | DATE SIGNED | | | | | | | |
| Charles P. Kokes | | M.D. Assistant | | 12-18-86 | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | Charles P. Kokes, M.D. | | ADDRESS | | 111 Penn St., Balto., MD | | 21201 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | | | |
| Burial | | 12/22/86 | | Arbutus Mem Pk. | | Baltimore, Md. | | | | | |
| 24. FUNERAL DIRECTOR NAME | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| Law Funeral Home | | DEC 30 1986 | | John D. D. D. | | | | | | | |
| 4611 Park Heights Ave. | | | | | | | | | | | |

ONE



15011 101100 2002

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15011

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|---|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
ROGER SCOTT | | | 2a. DATE OF DEATH
MONTH DAY YEAR
DECEMBER 26, 1986 | | 2b. HOUR
8:15 M |
| 3. SEX
Male | 4. RACE
Black | 5. DATE OF BIRTH
MONTH DAY YEAR
4 2 14 | | 6. AGE (IN YEARS LAST BIRTHDAY)
72 YRS | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE
(COUNTRY)
Delaware | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE JOHNS HOPKINS HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY
Heat Armour
Heat Packing |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
md | 13b. COUNTY | 13c. CITY OR TOWN
Balto | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
1006 E. Biddle St 21202 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
George Scott | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
217-07-9185 | | 17. INFORMANT
ADDRESS
Vermenka Scott 1006 E Biddle St. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIO pulmonary Arrest
DUE TO, OR AS A CONSEQUENCE OF
Gastrointestinal Bleeding
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 mins |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a
Cholangio carcinoma | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/26/86, 1986, to 12/26, 1986, that (I) (we) last saw the deceased alive on 12/26, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did) did not view the body after death. | | | | | |
| 22b. SIGNATURE
Mark Schlissel | | DEGREE
M.D. | | 22c. DATE SIGNED
12/26/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MARK Schlissel | | 22e. ADDRESS
600 N. WOLFE ST. BALTO, MD.
JOHNS HOPKINS HOSPITAL 21205 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
12-31-86 | 23c. NAME OF CEMETERY OR CREMATORY
Garrison Forest Cem | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Curing Md MD | |
| 24. FUNERAL DIRECTOR
NAME
Wm C March 7/H 1101 E North Ave | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR
DEC 30 1986 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
Julia Station-Rudess | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed by the attending physician within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be filed in by the funeral director, page 3 should be detached for use as the burial transit permit. Thereafter, please remove this certificate from the file and send it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

08-00000000000000000000000000000000

CERTIFICATE OF DEATH

8 6 3 4 9 3 5

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | |
|---|--|--|---|---|--|--|---|--|--------------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) William Edward Scott | | | 2a. DATE OF DEATH
MONTH 12 DAY 27 YEAR 86 | | | 2b. HOUR
M | | | | |
| 3. SEX
MALE | | 4. RACE
BLACK | | 5. DATE OF BIRTH
MONTH 3 DAY 9 YEAR 1916 | | 6. AGE (IN YEARS LAST BIRTHDAY)
70 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Balto. City MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Balto City | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
628 Willow Ave | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS
628 Willow Ave #12 | | | | |
| 13a. STATE
MD | | | 13b. COUNTY | | | 13c. CITY OR TOWN
Balto | | | | |
| 14. FATHER'S NAME
FIRST Edward MIDDLE LAST Scott | | | | 15. MOTHER'S MAIDEN NAME
FIRST Irene MIDDLE LAST Cooper | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO.
218-07-1088 | | 17. INFORMANT
Noline Scott | | | | ADDRESS
628 Willow Ave #12 | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) metastatic colon cancer
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from November 19 86 , to December 19 86 , that (I) (we) last saw the deceased alive on December 22 19 86 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Victoria Vanik MD | | | DEGREE | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12/29/86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
VICTORIA VANIK | | | 22e. ADDRESS
Brehms Lane Medical Center | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) BURIAL | | | 23b. DATE
12/31/86 | | 23c. NAME OF CEMETERY OR CREMATORY
Carrison Forest U.A. | | 23d. LOCATION
CITY OR TOWN Balto. COUNTY MD. STATE | | | |
| 24. FUNERAL DIRECTOR
NAME Jeff Miller Funeral Services #15 | | | ADDRESS 4611 Park Heights | | 25a. DATE REC'D. BY REGISTRAR
DEC 30 1986 | | 25b. REGISTRAR'S SIGNATURE
Julia Seaton-Randall | | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove page 1 and 2 and return them to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic death, the medical examiner must be notified at once.

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DEC 30 1988

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|---|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Rosie B. Scully | | | 2a. DATE OF DEATH
MONTH DAY YEAR
December 14, 1986 | | 2b. HOUR
M |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
July 25, 1898 | | 6. AGE (IN YEARS LAST BIRTHDAY)
88 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Va. | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
124 S. Collington Ave. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
Md. | 13b. COUNTY | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
124 S. Collington Ave. 21231 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John Tate | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Frances Whitt | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
233-62-6204 | | 17. INFORMANT ADDRESS
Flora Trent 124 S. Collington Ave. 21231 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Respiratory Arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Enterococcal sepsis</u> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>2 minutes</u>
<u>8 minutes</u>
<u>14 days</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Clostridium difficile colitis; Ischemic colitis</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>November 24, 1986</u> , to <u>December 8, 1986</u> , that (I) (we) lost saw the deceased alive <u>December 8, 1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>C. Lowell</u> | | DEGREE
<u>MD</u>
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED
<u>12/15/86</u> |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>C. Lowell</u> | | 22e. ADDRESS
<u>601 N. Broadway Baltimore, MD 21205</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | 23b. DATE
12-18-1986 | 23c. NAME OF CEMETERY OR CREMATORY
Oak Lawn | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Md. | |
| 24. FUNERAL DIRECTOR
NAME
JOHN M. WEBER & SONS INC. 401 S. CHESTER ST. | | | 25a. DATE REC'D. BY REGISTRAR
DEC 16 1986 | | |
| | | | 25b. REGISTRAR'S SIGNATURE
<u>Lia Davidson-Randall</u> | | |

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 3 4 9 3 7

FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | |
|---|--|---|---|---|--|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
WILBUR E. SEIDEL Sr. | | | 2a. DATE OF DEATH
MONTH DAY YEAR
DECEMBER 29, 1986 | | | 2b. HOUR
11:54A | | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
6 2 1920 | | 6. AGE (IN YEARS (LAST BIRTHDAY))
66 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 74 HRS
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE JOHNS HOPKINS HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | | 12b. KIND OF BUSINESS OR INDUSTRY
Beth Steel | | |
| 13a. STATE
Maryland | | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Dundalk | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Tarrington Seidel | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Julia Russell | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
no | | | | |
| 16b. SOCIAL SECURITY NO.
187-12-1988 | | | 17. INFORMANT ADDRESS
Eldora Seidel 1856 Marshall Rd. 21222 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Septic Shock</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Unknown Source of infection</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>48h</u>
<u>10 days</u> | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Severe Congestive Cardiomyopathy</u> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/18</u> , 19 <u>86</u> , to <u>12/29</u> , 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>12/29</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<u>Walter N. Kernan MD</u> | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED
<u>12/29/86</u> | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>Walter N. Kernan</u> | | | 22e. ADDRESS
<u>6 Johns Hopkins Hospital</u> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
1/2/86 | | 23c. NAME OF CEMETERY OR CREMATORY
Oak Lawn Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Md. | | | |
| 24. FUNERAL DIRECTOR
NAME
Connelly Funeral Home | | | | | ADDRESS
Dundalk | | 25a. DATE REC'D. BY REGISTRAR
JAN 6 1987 | | 25b. REGISTRAR'S SIGNATURE
<u>Julia D. ...</u> | |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the physician or attending physician.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the bottom paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified before any

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(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | |
|---|--|---|--------|---|---|---|--|---|
| DECEASED NAME
(TYPE OR PRINT) | | FIRST
GEORGE | MIDDLE | LAST
SEIDMAN | 2a. DATE OF DEATH MONTH DAY YEAR
DECEMBER 19, 1986 | | 2b. HOUR
4am AM | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
3 14 1902 | | 6. AGE (IN YEARS LAST BIRTHDAY)
82 84 YRS | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 74 HRS
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
NEW YORK | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
598 S. BEECHFIELD AVE. (21229) | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
PROPRIETOR | | 12b. KIND OF BUSINESS OR INDUSTRY
CAR WASH |
| 13a. STATE
MARYLAND | | 13b. COUNTY | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
HARRY SEIDMAN | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
BESSIE UNKNOWN | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | | | |
| 16b. SOCIAL SECURITY NO.
218-30-5992 | | 17. INFORMANT MRS. BETTY BERLIN
7505 LABYRINTH RD. BALTO., MD 21208 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Cerebral arteriosclerosis</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>Immediate</u>
<u>10 years</u> | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9/8</u> , 19 <u>72</u> , to <u>12/15/</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>12/15</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE
<i>W. K. Gallagher, Jr.</i> | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
12/19/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Wilmer K. Gallagher, Jr., M.D. | | | | 22e. ADDRESS
3455 Wilkens Avenue, Balto. MD 21229 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
15a. METHOD
BURIAL | | 23b. DATE
DEC. 21, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY
PETACH TIKVAH | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
ROSEDALE BALTO. MD | | |
| 24. FUNERAL DIRECTOR
NAME SOL LEVINSON & BROS.
6010 REISTERSTOWN RD. BALTO., MD. (21215) | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 30 1986 | | 25b. REGISTRAR'S SIGNATURE
<i>Julia Davidson-Randall</i> | | |

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DEC 20 1985

027108 DEC 15 1986

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 3 4 9 3 9

REGISTRAR

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
HENRY J. SEIFERT | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12-5-86 | | | 2b. HOUR
6:55 AM | |
| 3. SEX
MALE | | 4. RACE
CAUC. | | 5. DATE OF BIRTH
MONTH DAY YEAR
10 4 28 | | 6. AGE (IN YEARS LAST BIRTHDAY)
58 YRS | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
MD | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNIV. OF MARYLAND | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
unknown | |
| 13a. STATE
MD | | | | 13b. COUNTY
BALT. | | 13c. STREET ADDRESS / ZIP CODE
1451 WASHINGTON BLVD 21230 | |
| 14. FATHER'S NAME
(TYPE OR PRINT)
John Wm. Seifert, SR. | | | | 15. MOTHER'S MAIDEN NAME
(TYPE OR PRINT)
Carrie ? | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
yes | | | | 16b. SOCIAL SECURITY NO.
216-54-6434 | | 17. INFORMANT
Christine Seifert 1451 Washington Blvd | |

| | | |
|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
* 9289 IMMEDIATE CAUSE (a) CARDIO-PULMONARY ARREST
DUE TO, OR AS A CONSEQUENCE OF
(b) INTRACEREBRAL HEMATOMA
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|--|--|--|

| | | | |
|---|--|--|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NEAR <input type="checkbox"/> AT WORK <input type="checkbox"/> | |
| 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/12, 1986, to 12/5, 1986, that (I) (we) last saw the deceased alive on 12/5, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
Michael W. Rand | | 22c. DATE SIGNED
12/15/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
J. MICHAEL RAND | | 22e. ADDRESS
22 South Greene, BALT. | |

| | | | | | | | |
|--|--|------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
12-8-1986 | | 23c. NAME OF CEMETERY OR CREMATORY
Westview Mem. Park | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Balt. Co. Md. | |
| 24. FUNERAL DIRECTOR
John Wm. Seifert, Jr. | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 10 1986 | | | |
| 25b. REGISTRAR'S SIGNATURE
John Davidson-Randall | | | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Thereafter follow carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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100% COTTON FIBER

[Faint, illegible text and markings are visible across the page, likely bleed-through from the reverse side.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) WILLIAM SEITZ | | | | 2a. DATE OF DEATH
MONTH DAY YEAR DECEMBER 12, 1986 | | | |
| 3. SEX
MALE | | | | 2b. HOUR
1:20pm | | | |
| 4. RACE
white | | 5. DATE OF BIRTH
MONTH DAY YEAR 7 24 1909 | | 6. AGE (IN YEARS LAST BIRTHDAY)
77 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
GOOD SAMARITAN HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
OIL OPERATOR | | 12b. KIND OF BUSINESS OR INDUSTRY
COPPER REFINING | |
| 13a. STATE
MARYLAND | | | | 13b. CITY OR TOWN
PASADENA | | 13c. STREET ADDRESS / ZIP CODE
8470 BEDFORD RD. PASADENA MD. 21122 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
WILLIAM SEITZ SR. | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
BARBARA HORNER | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
21303 6955 | | 17. INFORMANT ADDRESS
ROBERT SEITZ 8470 BEDFORD RD. PASADENA MD. 21122 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Left sided Cerebrovascular Accident
DUE TO, OR AS A CONSEQUENCE OF BRAINstem Infarct
(b) _____
DUE TO, OR AS A CONSEQUENCE OF _____
(c) _____
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK
NO! WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11-24-86 , 19 86 , to 12-12-1986 , that (I) (we) lost
saw the deceased alive on 12-12-1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Lokeswara Rao Edara | | | | DEGREE
MD | | 22c. DATE SIGNED
12-12-86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
LOKESWARA RAO EDARA | | | | 22e. ADDRESS
Baltimore, MD.
910 GOOD SAMARITAN HOSPITAL | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) BURIAL | | 23b. DATE
12/15/86 | | 23c. NAME OF CEMETERY OR CREMATORY
LOUDON PARK CEMETERY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE MARYLAND | |
| 24. NAME OF FUNERAL HOME
HEROYAL M & RUSSELL C. WITZKE FUNERAL HOMES | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 16 1986 | | 25b. REGISTRAR'S SIGNATURE
Lelia Davidson-Randall | |
| 1630 EDMONDSON AVENUE BALTIMORE MARYLAND 21228 | | | | | | | |

028924 JAN - 207

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 3 4 9 4 1

REG. NO.

| | | | | | | | | | | |
|--|--|--|---|---|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) DONALD D SELLERS | | | 2a. DATE OF DEATH MONTH DAY YEAR
DEC. 22 1986 | | | 2b. HOUR
8 50 A.M. | | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
03 03 30 | | 6. AGE (IN YEARS LAST BIRTHDAY)
56 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
CLEVELAND, OHIO | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
John L. Deaton Med. Center | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Sheet Metal | | 12b. KIND OF BUSINESS OR INDUSTRY
Kogok Co. | | |
| 13a. STATE
Maryland | | | 13b. COUNTY
Prince George's | | | 13c. CITY OR TOWN
Laurel | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
David ----- Sellers | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Leona ----- Clark | | | 13e. STREET ADDRESS / ZIP CODE
8 Woodland Ct. 101, Laurel MD 20810 | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | | 16b. SOCIAL SECURITY NO.
282-24-9445 | | | 17. INFORMANT ADDRESS
Mrs. Lois Sellers, Same as above | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Cardiorespiratory failure
DUE TO, OR AS A CONSEQUENCE OF
(b) Recurrent CVA's
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 27 March 1985 to 22 Dec 1986 that (I) (we) lost saw the deceased alive on 22 Dec 1986 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
J.W. Reed M.D. | | | | | | DEGREE
M.D. | | 22c. DATE SIGNED
12/22/86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
J.W. REED M.D. | | | | | | 22e. ADDRESS
611 S. CHAS. ST. BALTO. MD 21230 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | | 23b. DATE
12/22/86 | | 23c. NAME OF CEMETERY OR CREMATORY
Security Process, Inc. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Catonsville, Balto. Co. Md | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Balto. Md. 21230
McCully Funeral Home, 130 E. Fort Ave. Balto | | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 30 1986 | | 25b. REGISTRAR'S SIGNATURE
Davidson-Randall | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, a medical examiner must be notified at once.

BP _____

CLASSIFICATION

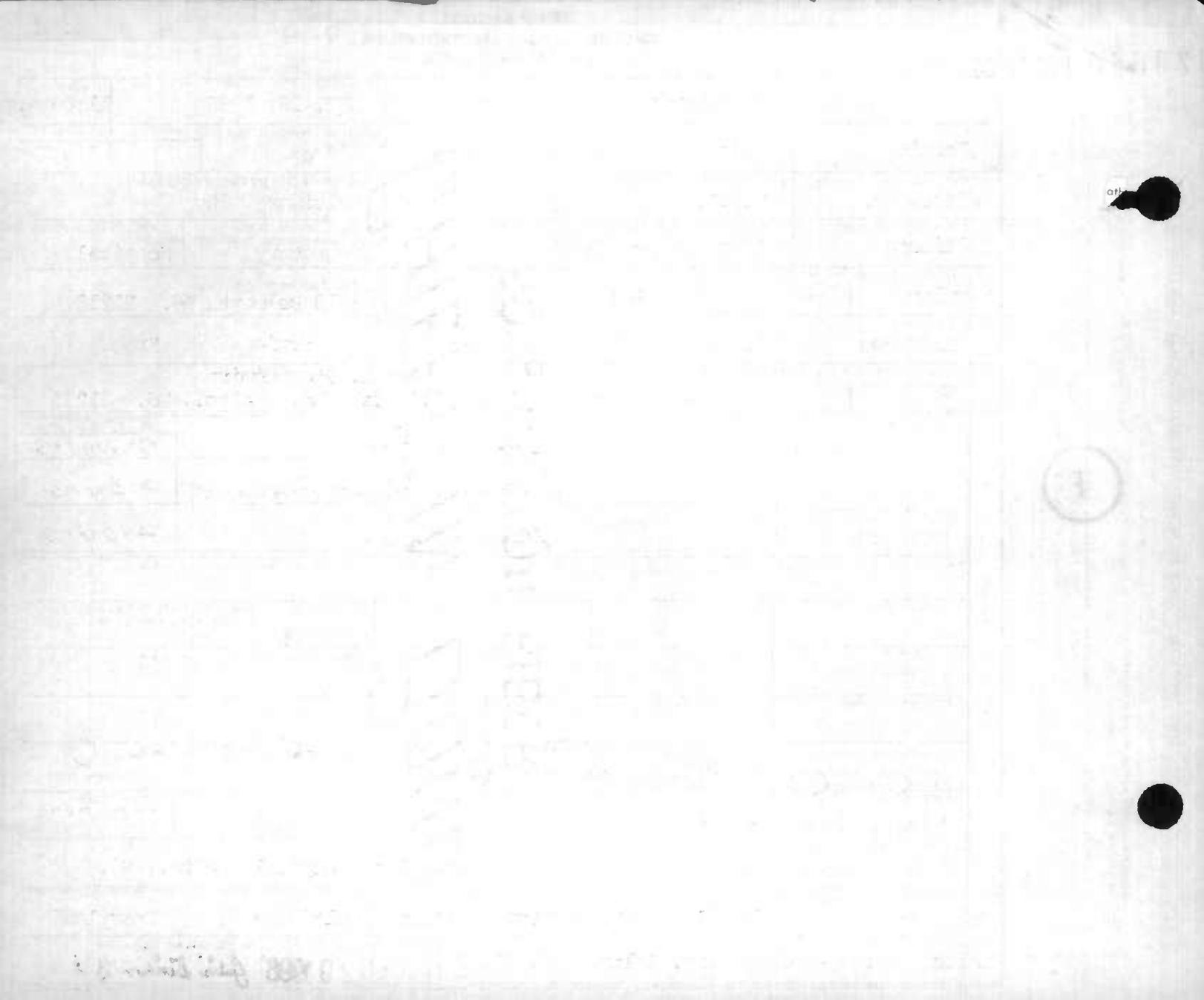


Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the ballpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 8 6 3 4 9 4 2 | |
|---|--|---|-------------------------|---|--|---|--|--|---|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | |
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
DORIS SToudenMIRE SEITZ | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
DEC. 26, 1986 | | | 2b. HOUR
11:00 a.m. | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
Nov. 3, 1918 | | 6. AGE (IN YEARS LAST BIRTHDAY)
68 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Balto., Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
1513 Ralworth Road | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Secretary | | | 12b. KIND OF BUSINESS OR INDUSTRY
Hospital | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13b. STATE
Maryland | | | | | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
1513 Ralworth Rd. 21218 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Laurence C. Stoudenmire | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Anna Marie Brack | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO.
217.97.8038 | | 17. INFORMANT ADDRESS
Jay H. Stoudenmire
6729 Collinsdale Rd. Balto., Md. 21234 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1: DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>MINUTES</u> | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | DUE TO, OR AS A CONSEQUENCE OF (b) <u>CONGESTIVE HEART FAILURE</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>HYPERTENSION</u> | |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>NO</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1 JAN</u> 19 <u>86</u> to <u>26 DEC</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>1 NOV</u> 19 <u>86</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.) | | | | | | | | | | | |
| 22b. SIGNATURE
<u>John F. Rogers MD</u> | | | | | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12/27/1986 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
John F. Rogers, M.D. | | | | | | 22e. ADDRESS
Good Samaritan Hospital, Balto., Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | | 23b. DATE
12/29/1986 | | 23c. NAME OF CEMETERY OR CREMATORY
Green Mount Cemetery | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Maryland | | | |
| 24. FUNERAL DIRECTOR
Walter Brooks Bradley, Inc. Balto., Md. 21222 | | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 29 1986 | | 25b. REGISTRAR'S SIGNATURE
<u>Julia Benison-Randall</u> | | | |



027585

FOR
STATE
REGISTRATION

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | | | | | | | |
|---|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|----------------------|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) HARRY | | | FIRST 210yd | | | MIDDLE SELLERS | | | LAST | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTI- MATED <input type="checkbox"/> 12 10 1986 | | | 2b. HOUR M | | | | | |
| 3. SEX MALE | | | 4. RACE BLACK | | | 5. DATE OF BIRTH FEB. 1, 1941 | | | 6. AGE (IN YEARS LAST BIRTHDAY) 45 YRS. | | | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | | | 7c. DATE PRONOUNCED DEAD 12 10 1986 | | | 2d. HOUR 8P M | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Sic | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hosp. (STU) | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LABOR | | | 12b. KIND OF BUSINESS OR INDUSTRY VARIOUS | | | | | | | | |
| 13a. STATE MD. | | | 13b. CITY OR TOWN QUEEN ANNE'S | | | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13d. STREET ADDRESS R. 50 | | | 13e. STREET ADDRESS 2166b | | | | | | | | |
| 14. FATHER'S NAME FIRST 210yds MIDDLE LAST SELLERS | | | 15. MOTHER'S MAIDEN NAME FIRST SAVANNAH MIDDLE LAST UNK. | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO | | | 16b. SOCIAL SECURITY NO. 247-64-8849 | | | 17. INFORMANT ADDRESS MRS. ELM SELLERS 118 PORT ST. EASTON, MD. | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Multiple injuries
8147
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.
(b)
(c)
DUE TO, OR AS A CONSEQUENCE OF
DUE TO, OR AS A CONSEQUENCE OF
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 1a. | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY 6:40 A.M. 12-10-1986 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Pedestrian struck by auto. | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road | | | 21f. LOCATION STREET Rt. 50 e. of Bay Bridge | | | CITY OR TOWN Queen Anne's, MD | | | COUNTY Queen Anne's, MD | | | STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held on: Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE Charles P. Kokes | | | TITLE (SPECIFY) Assistant | | | M.D. Assistant | | | MEDICAL EXAMINER | | | DATE SIGNED 12-11-86 | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Charles P. Kokes, M.D. | | | ADDRESS 111 Penn St., Balto., MD 21201 | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | 23b. DATE 12-15-1986 | | | 23c. NAME OF CEMETERY OR CREMATORY ROSEVILLE CEM. | | | 23d. LOCATION CITY OR TOWN PRICE | | | COUNTY B.A | | | STATE MD. | | | | | |
| 24. FUNERAL DIRECTOR NAME Charles W. Kokes | | | ADDRESS CHESTER TOWN MD | | | 25a. DATE REC'D. BY REGISTRAR DEC 18 1986 | | | 25b. REGISTRAR'S SIGNATURE Julia Anderson-Randall | | | | | | | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD-21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP
DHMH - 17
(VR ATS ME (S))

028421 DEC 30 1986

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|-------------------------|--|---|---|-----------------------------|
| 1. DECEASED NAME
(TYPE OR PRINT) VERONICA L. SHARP | | | 2a. DATE OF DEATH
MONTH 12 DAY 25 YEAR 86 | | 2b. HOUR
1:20 A M |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH Mar. DAY 23 YEAR 1901 | | 6. AGE (IN YEARS LAST BIRTHDAY)
85 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New York | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Bon Secours Hospital | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
New Jersey | | 13b. COUNTY
Somerset | 13c. CITY OR TOWN
Somerville | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST Charles MIDDLE M. LAST Doube | | 15. MOTHER'S MAIDEN NAME
FIRST Mary MIDDLE Dougherty LAST Dougherty | | 13e. STREET ADDRESS / ZIP CODE
1 Mountain Avenue 99999 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
146-24-8585 | | 17. INFORMANT
Cusick Funeral Home ADDRESS Somerville, N.J. | |

| | | |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIAC ARREST | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| DUE TO, OR AS A CONSEQUENCE OF ARTERIOSCLEROTIC CARDIOVASCULAR disease | | |
| (b) CONGESTIVE HEART FAILURE | | |
| DUE TO, OR AS A CONSEQUENCE OF SENILE DEMENTIA | | |
| (c) | | |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

| | | | | | |
|---|--|--|--|--|---|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/25 19 86 , to 12/25 19 86 , that (I) (we) lost
saw the deceased alive on 12/25 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) did (did not) view the body after death. | | 22b. SIGNATURE
Kuang-yen Huang MD | | 22c. DATE SIGNED
12/25/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
KUANG-YEN HUANG M.D. | | 22e. ADDRESS
Bon Secours Hospital | | | |

| | | | |
|--|---------------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) Burial | 23b. DATE
Dec 29 1986 | 23c. NAME OF CEMETERY OR CREMATORY
Somerset Hill Cem. | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Bernards Township N.J. |
| 24. FUNERAL DIRECTOR
NAME Leonard J. Ruck, Inc. ADDRESS Baltimore, Maryland | | | 25a. DATE REC'D. BY REGISTRAR DEC 29 1986 25b. REGISTRAR'S SIGNATURE Asia Davidson-Randall |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | |
|---|--|---|---|--|--|
| 1. FOR STATE REGISTRAR | | | | 20. DATE OF DEATH MONTH DAY YEAR | |
| 2. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST | | | | 26. HOUR | |
| Joseph R Rudolph Shayda | | | | 12 30 86 1:00 PM | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR IF UNDER 24 HRS | |
| Male | Caucasian | 12 8 10 | 76 YRS. | MONTHS DAYS | HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Pennsylvania | U.S. | | Baltimore City MD. | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| Baltimore | Merry Hosp. to 1 | | Retired | | Bethlehem Steel |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | 13b. COUNTY | 13c. CITY OR TOWN | 13d. STREET ADDRESS / ZIP CODE | | |
| Maryland | Baltimore | Baltimore | 413 Macon St 21224 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | |
| Paul Shayda | Cecelia + Halenar Halenar | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | 17. INFORMANT ADDRESS | | | |
| No | 213072356 | Alberta M. Shayda 413 S. Macon St. 21224 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Metastatic Ca of Colon</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Carcinoma of Colon</u> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| N/A | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| | P.M. 19 | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/29</u> 19 <u>86</u> , to <u>12/30</u> 19 <u>86</u> , that (I) (we) lost
saw the deceased alive on <u>12/30</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) did (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | |
| Valerie L. Moore MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 12/30/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| Valerie L. Moore MD | | 301 St. Paul Place Baltimore MD 21202 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN COUNTY STATE | | |
| Burial | 1-02-87 | Sacred Heart of Jesus | Dundalk, Balto. Co., Md. | | |
| 24. FUNERAL DIRECTOR NAME | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Charles S. Zeiler & Son Inc. 6224 Eastern Ave. | | DEC 31 1986 | | Julia T. ... | |

21

[Faint bleed-through from reverse side]

026353 DEC 8 1986

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 34746

REG. NO.

| | | | | | | | |
|---|--|--|---|---|------------------------------|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
LUCILLE SHEFFLER | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12-4-86 | | 2b. HOUR
9:45 A.M. | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
July 3 07 | | 6. AGE (IN YEARS LAST BIRTHDAY)
79 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
St. Agnes Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Loom Operator | | 12b. KIND OF BUSINESS OR INDUSTRY
Silk Mill | |
| 13a. STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
UNKNOWN Strickler | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
UNKNOWN UNKNOWN | | 13e. STREET ADDRESS / ZIP CODE
2671 Frederick Avenue, 21223 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
224-10-8429 | | 17. INFORMANT
Margaret Addair, 2671 Frederick Avenue | | | |

| | | | |
|--|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Fibrosis | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
Monote | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | DUE TO, OR AS A CONSEQUENCE OF (b) Acute Myocardial Ischemia | |
| | | DUE TO, OR AS A CONSEQUENCE OF (c) Coronary Disease of Aortic Atherosclerosis | |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11-6 , 19 79 , to 12-4 , 19 86 , that (I) (we) last saw the deceased alive on 11-16 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Dr. Swisher | | | | DEGREE
MD | | 22c. DATE SIGNED
12-4-86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Dr. Swisher | | | | 22e. ADDRESS
St. Agnes Medical Center | | | |

| | | | | | | | |
|---|--|-----------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Entombment | | 23b. DATE
12/6/86 | | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park Mausoleum | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Maryland | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Hubbard Funeral Home, Inc. 4107 Wilkens Ave. 21229 | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 5 1986 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or called.

[Faint, illegible text covering the majority of the page, likely bleed-through from the reverse side.]

FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Audrey V. W Sheppard | | 2a. DATE OF DEATH
MONTH DAY YEAR
12-7-86 | | 2b. HOUR
MIN.
12:04 | |
| 3. SEX
F | | 4. RACE
B | | 5. DATE OF BIRTH
MONTH DAY YEAR
08 28 24 | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
Md | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Sinai Hospital | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Unemployed | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
Md | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Winfield Wongus | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Magdalene Stanley | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | |
| 17. INFORMANT
ADDRESS
Sarah W. Jones 743 Richwood Ave | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Circulatory Collapse
DUE TO, OR AS A CONSEQUENCE OF
(b) Respiratory arrest and bradycardia 15 hr.
DUE TO, OR AS A CONSEQUENCE OF
(c) Widely Metastatic Breast Cancer
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
2/207 | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | |
| 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | 22a. I certify that (I) (this hospital) attended the deceased from 11-24 , 19 86 , to 12-7 , 19 86 , that (I) (we) lost
saw the deceased alive on 12-6 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE
Stephen Charles Sprungate MD | |
| 22c. DATE SIGNED
12-7-86 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Stephen Charles Sprungate | | 22e. ADDRESS
Sinai Hospital Baltimore | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
12/11/86 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Anne Arundel Co Md | | 24. FUNERAL DIRECTOR
NAME ADDRESS
March Funeral Home West 4300 Wabash Avenue | | 25a. DATE REC'D. BY REGISTRAR
DEC 10 1986 | |
| 25b. REGISTRAR'S SIGNATURE
[Signature] | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 12 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of date.

MEDICAL CERTIFICATION

036879 0000000000

036879 0000000000

DEPT OF AGRICULTURE

100-100000

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | |
|--|--|--|--|---|----------------------------|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
MILDRED SHERMAN | | | 2a. DATE OF DEATH MONTH DAY YEAR
DECEMBER 23, 1986 | | 2b. HOUR
11:55A. | | | | | | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
2 23 02 | | 6. AGE (IN YEARS LAST BIRTHDAY)
85 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
0 0 0 0 | | IF UNDER 72 HRS.
HOURS MIN.
0 0 | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Balto. City MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Balto. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Church Hosp. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Sales clerk. | | 12b. KIND OF BUSINESS OR INDUSTRY
retail | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md. | | | | | | 13b. COUNTY
BALTO | | 13c. CITY OR TOWN
Balto. | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
7232 German Hill Rd. 21222 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Orville Butler | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ms. Leslie Butler | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Unkn. | | 16b. SOCIAL SECURITY NO.
216-07-3705 | | 17. INFORMANT
Ms. Leslie Butler | | 1306 ADDRESS
Morling Ave. | | Balto., Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) MULTIPLE CEREBROVASCULAR ACCIDENTS | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | | |
| DUE TO, OR AS A CONSEQUENCE OF
(b) CHRONIC ANAL FIBRILLATION | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) SEVERE CHRONIC OBSTRUCTIVE PULMONARY DISEASE | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
SEIZURE DISORDER | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION
DECEMBER 4, 1986 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
UNABLE TO WEAN FROM RESPIRATOR | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED
(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from DECEMBER 17, 1986 to DECEMBER 23, 1986 , that (I) (we) last saw the deceased alive on DECEMBER 23, 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE
G. Ramesh | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
RAMESH SABAPATHI | | | | 22e. ADDRESS
CHURCH HOSPITAL CORPORATION
100 N. BROADWAY BALTO., MD 21231 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Removal | | 23b. DATE
12-24-86 | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Anatomy Board | | | | ADDRESS
Balto., Md. | | 25a. DATE REC'D. BY REGISTRAR
JAN 12 1987 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

6

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | |
|--|--|--|--|--|--|--|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
IDA SHIELDS | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12/27/86 | | | 2b. HOUR
1220 AM | | | | |
| 3. SEX
F | | 4. RACE
B | | 5. DATE OF BIRTH
MONTH DAY YEAR
12 24 1902 | | 6. AGE (IN YEARS LAST BIRTHDAY)
84 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
USA | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE MD. | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Liberty Medical Center | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
MD | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
DuKeland N.H. 21216 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Henry Parran | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
UNKNOWN | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
215-03-5049 | | 17. INFORMANT
Caladys Gray | | | | ADDRESS
1101 Bolton St. apt 812 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Advanced lung disease
DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD, CTE
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }
DUE TO, OR AS A CONSEQUENCE OF (c) Chronic failure | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/6/86 , 19 86 , to 12/27 , 19 86 , that (I) (we) last saw the deceased alive on 12/26 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Mark Davis | | | DEGREE
MD | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12/27/86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MARK DAVIS MD | | | 22e. ADDRESS
6051 BALTIMORE PIKE EL MD 21043 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
12/30/86 | | 23c. NAME OF CEMETERY OR CREMATORY
Balto. Nat Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Md. | | | |
| 24. FUNERAL DIRECTOR
NAME
Wm C March F/H West | | | | | ADDRESS
4300 Wabash Ave. | | 25a. DATE REC'D. BY REGISTRAR
DEC 30 1986 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please take this certificate to the funeral home. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or any significant event, the medical examiner must be notified of same.

1

COTTON

DEPT

1944

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | |
|--|--|---|---|---|---|--|--|---|--|--|
| FOR STATE REGISTRAR | | | | | REG. NO. | | | | | |
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
BARBARA Mae SHIFFLETT | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
12 02 86 | | | 2b. HOUR
1026AM | | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR
02 07 26 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.
60 | | 7. IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
University Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Bookkeeper | | 12b. KIND OF BUSINESS OR INDUSTRY
F.A. Davis Co. | | |
| 13a. STATE
Maryland | | | | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Thomas Alexander Levering | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE
Mamie Waltz | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
no | | | | | 16b. SOCIAL SECURITY NO.
216-20-7491 | | 17. INFORMANT Mr. Shifflett Jr.
3415 Abbie Place Baltimore, MD. 21207 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST
DUE TO, OR AS A CONSEQUENCE OF (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
45 min | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
DIABETES, HEART DISEASE | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/2 1986, to 12/2 1986, that (I) (we) lost saw the deceased alive on 12/2 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
M. DURANTE | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
12/2/86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
M. DURANTE | | | | | 22e. ADDRESS
UNIV. MARYLAND HOSPITAL
22 S. GREENE ST. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
12/5/86 | | 23c. NAME OF CEMETERY OR CREMATORY
Lorraine Park Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Baltimore Baltimore MD. | | | | |
| 24. FUNERAL DIRECTOR NAME
Loring Byers Funeral Directors, Inc.
8728 Liberty Road Randallstown, MD. 21133 | | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 5 1986 | | 25b. REGISTRAR'S SIGNATURE | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/B4 (VRA 15, 4)

026551 DEC 10 1986

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 3 4 9 3 1

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1. DECEASED NAME | | | 2a. DATE OF DEATH | | | 2b. HOUR | |
|--|--------|---------|---|-----|------|---|--|
| FIRST | MIDDLE | LAST | MONTH | DAY | YEAR | | |
| Robert | G. | Shouman | 12 | 06 | 86 | 3:30 P | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | |
| Male | | | White | | | MONTH DAY YEAR | |
| | | | 03 05 31 | | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| | | | 55 | | | 7. IF UNDER 1 YEAR | |
| | | | | | | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | |
| West Virginia | | | USA | | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH | | | 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION | |
| Baltimore City | | | Baltimore | | | Union Memorial Hospital | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| Carpenter | | | | | | | |
| 13a. STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | |
| Maryland | | | | | | Baltimore | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | 13d. STREET ADDRESS / ZIP CODE | |
| Robert | | | Alice | | | 3500 Keswick Road 21211 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT ADDRESS | |
| No | | | 213-28-4581 | | | Helen Q. Shouman 7 E. Red Mare Ct. 21030 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | |
| IMMEDIATE CAUSE (a) Hemoptysis | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| (b) Lung Cancer | | | | | | 1 yr | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| (c) | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | |
| | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| | | | P.M. 19 | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/6/86 to 12/10/86, that (I) (we) last saw the deceased at 12/6/86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If true) (did/did not) saw the body after death. | | | 22b. SIGNATURE (NAME OR PRINT) | | | 22c. DATE SIGNED | |
| | | | Richard L Diamond MD | | | 12-9-86 | |
| 22d. PHYSICIAN'S NAME (NAME OR PRINT) | | | 22e. ADDRESS | | | | |
| RICHARD L DIAMOND | | | 3547 Chestnut Ave Balt Md 21211 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Burial | | | 12/10/86 | | | Lorraine Park Cem. | |
| | | | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| | | | | | | Baltimore Maryland | |
| 24. FUNERAL DIRECTOR | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | |
| A. Alan Seitz, Jr. 3615-19 Chestnut Ave. 21211 | | | DEC 9 1986 | | | Julia Davidson-Randall | |

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COMMON

22

027279 DEC

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | |
|--|--|---|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| KEITH E. SIDES | | | DECEMBER 12, 1986 | | | 8:40p M | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | | | 7. IF UNDER 1 YEAR | | |
| Male | White | MONTH 4 DAY 20 YEAR 48 | 38 YRS | | | MONTHS DAYS HOURS MIN. | | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 9. CITIZEN OF WHAT COUNTRY? | 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Ohio | U.S.A. | | BALTIMORE CITY MD. | | | | | |
| 11. CITY OR TOWN OF DEATH | 12. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| BALTIMORE | THE JOHNS HOPKINS HOSPITAL | | Photographer. | | | Photography | | |
| 13a. STATE | | | 13b. CITY OR TOWN | | | 13c. STREET ADDRESS / ZIP CODE | | |
| Pennsylvania | | | State Line | | | 582 East Avenue 17263 | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | 16. ADDRESS | | |
| Lester H. Sides | | | Martha M. Rurode | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | |
| NO | | | 290-50-7767 | | | Martin Zimmerman | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | |
| (b) <u>Sepsis</u> | | | | | | 45 min. | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | |
| (c) <u>Immune suppression</u> | | | | | | 4 days. | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | |
| <u>Renal Failure.</u> | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | |
| | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. TIME OF INJURY | | | 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | |
| | | | HOUR A.M. MONTH DAY YEAR | | | | | |
| | | | P.M. 19 | | | | | |
| 21a. INJURY OCCURRED | | | 21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21c. LOCATION | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | | STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (this hospital) attended the deceased from <u>Dec. 7</u> , 19 <u>86</u> , to <u>Dec. 12</u> , 19 <u>86</u> , that (we) last saw the deceased alive on <u>Dec. 12</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE | | | 22c. DATE SIGNED | | | | | |
| <u>S. Melley</u> | | | 12/12/86 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22e. ADDRESS | | | | | |
| <u>S. Melley</u> | | | <u>The Johns Hopkins Hospital</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | |
| Burial | | | 12/16/86 | | | Browns Mill Cemetery | | |
| 24. FUNERAL DIRECTOR | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | |
| NAME ADDRESS 21229 | | | DEC 15 1986 | | | <u>Julia Tisdale-Padua</u> | | |
| Hubbard Funeral Home, Inc. 4107 Wilkens Ave. | | | | | | | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. BALTIMORE MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed and signed by the attending physician and completely filled in by the funeral director. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. If item 21 is marked as item 18 shows any injury, or other traumatic event, a medical examiner must be notified and a report filed.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial permit. Then please remove card page 3 and file it with the State Dept. of Health and Mental Hygiene.

DHMH - 16-60M 7/84
(VDA 15, 4)

41

4
026744 DEC

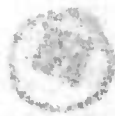
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon copy and return to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. If item 21 is marked or item 18 shows any injury, or other traumatic cause of death, the funeral examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
MILDREN M. SIEMER | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 9 86 | | | 2b. HOUR
0815 M | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
10 27 12 | | 6. AGE (IN YEARS LAST BIRTHDAY)
74 YRS | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Mercy Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Janitor | | 12b. KIND OF BUSINESS OR INDUSTRY
Public Schools | |
| 13a. STATE
Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS, / ZIP CODE
1206 Carroll Street 21230 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Lewis Delich | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Anna Volkmann | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
214-40-7574 | | 17. INFORMANT
ADDRESS
Louis G. Siemer 293 Berkeley Dr. 21146 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>End stage metastatic disease</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Gross hepatic metastases</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Carcinoma of breast</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 week
4 mo
1 yr | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION
12/9/86 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Carcinoma of breast | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/9/86</u> to <u>Dec 12/9/86</u> , that (I) (we) last saw the deceased alive on <u>12/9/86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
S. Demarcott M.D. | | | | DEGREE
ATTENDING PHYSICIAN | | | | 22c. DATE SIGNED
12/9/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
S. DEMARCO TT | | | | 22e. ADDRESS
333 ST PAUL PL BALTO 21202 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
12/12/86 | | 23c. NAME OF CEMETERY OR CREMATORY
St. Paul Luth. Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Violetville Md. | | | |
| 24. FUNERAL DIRECTOR
NAME
Hubbard Funeral Home, Inc. | | | | ADDRESS
21229
4107 Wilkens Ave. | | 25a. DATE REC'D. BY REGISTRAR
DEC 10 1986 | | 25b. SIGNATURE
Julia... | |

05874 02 11 03

X



05874 02 11 03

026935 DEC 12 1986

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please return page 3 to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|---|--|--|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Lillian Sophia Sigai | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 8 86 | | 2b. HOUR
12:44 A.M. | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
12 2 17 | | 6. AGE (IN YEARS LAST BIRTHDAY)
69 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Balt. City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Balto. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Francis Scott Key Hosp | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | | 12b. KIND OF BUSINESS OR INDUSTRY
Social Sec. Adm | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13b. STATE Maryland 13c. COUNTY Baltimore 13d. CITY OR TOWN Baltimore | | | | | | 13e. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13f. STREET ADDRESS / ZIP CODE
42 South Drew Street 21224 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Andrew Sigai | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Page | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO.
217-03-0866 | | 17. INFORMANT ADDRESS
Dorothy M. Mills 6720 Brentwood Ave. 21222 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio pulmonary Arrest
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a)
History of heart disease, previous myocardial infarction | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from December 7, 19 86 to December 8, 19 86 that (I) (we) last saw the deceased alive on Dec 8, 19 86 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
M. Fingerhood MD | | | | | | DEGREE
MD | | 22c. DATE SIGNED
12/8/86 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
M. Fingerhood | | | | | | 22e. ADDRESS
Francis Scott Key Med Ctr, 4990 Eastern Ave
Balt. MD 21224 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) Burial | | | | 23b. DATE
12-11-86 | | 23c. NAME OF CEMETERY OR CREMATORY
Gardens of Faith | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Overlea, Balto. Co., Md. | | | |
| 24. FUNERAL DIRECTOR
NAME
Charles S. Zeiler & Son Inc. | | | | | | ADDRESS
6224 Eastern Ave. | | 25a. DATE REC'D. BY REGISTRAR
DEC 10 1986 | | 25b. REGISTRAR'S SIGNATURE
John Davidson-Randall | |

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028403 DEC 10 1986

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|----------------------------|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
FRANCES SIMMONS | | | 2a. DATE OF DEATH MONTH DAY YEAR
DECEMBER 15, 1986 | | 2b. HOUR
2:30 PM | | |
| 3. SEX
Female | | 4. RACE
Chm | | 5. DATE OF BIRTH
MONTH DAY YEAR
3/31/16 | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS. MONTHS DAYS HOURS MIN.
70 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD | |
| 10. CITY OR TOWN OF DEATH
Balt. Md. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Church Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Saint George - retired | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Md | | 13b. COUNTY
Balt | | 13c. CITY OR TOWN
Balt | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | 13e. STREET ADDRESS ZIP CODE
501 W. Franklin St | | | |

| | | | | | |
|---|--|---|--|---|--|
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
217-016151 | | 17. INFORMANT
ADDRESS
Sgt. H. V. M. 501 W. Franklin St | |
|---|--|---|--|---|--|

| | | | |
|---|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST
DUE TO, OR AS A CONSEQUENCE OF (b) SECONDARY TO CONGESTIVE HEART FAILURE,
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) MULTIPLE MYELOMA
DUE TO, OR AS A CONSEQUENCE OF (c) AMYLOIDOSIS | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
|---|--|--|--|

| | | | |
|--|--|--|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | |
|--|--|--|--|

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |

| | | | | | |
|--|--|--|--|-------------------------------------|--|
| 22a. I certify that (1) (this hospital) attended the deceased from NOVEMBER 28, 1986 , DECEMBER 15, 1986 , that (1) (we) lost sight of the deceased alive on DECEMBER 15, 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (2) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE
Walker Impagliatelli
DEGREE | | 22c. DATE SIGNED
12/15/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
WALKER IMPAGLIATELLI M. D. | | 22e. ADDRESS
CHURCH HOSPITAL CORP. 100 NORTH BROADWAY BALTIMORE, MD. 21231 | | | |

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
Burial | | 23b. DATE
12/23/86 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Auburn Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balt. City Md | |
| 24a. FUNERAL DIRECTOR
NAME
Charles W. North Ave | | 24b. DATE REC'D. BY REGISTRAR
DEC 24 1986 | | 25b. REGISTRAR'S SIGNATURE
Julia T. ... | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove transit papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



029409 JAN 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | |
|--|--|---|--|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
Bessie Simms | | | 2a. DATE OF DEATH
MONTH DAY YEAR
December 17 1986 | | 2b. HOUR
7:10 P.M. |
| 3. SEX
F | 4. RACE
B | 5. DATE OF BIRTH
MONTH DAY YEAR
1 7 18 | | 6. AGE (IN YEARS LAST BIRTHDAY)
68 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD. | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore, City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Maryland General Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Domestic | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
MD. | | | 13b. COUNTY | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Samuel S. Miller | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Coryetha Bell | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
217-14-1051 | | 17. INFORMANT
ADDRESS
ANNA NELSON 2745 RIGGS | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cardiac Arrest

DUE TO, OR AS A CONSEQUENCE OF

Pulmonary Edema, Acute Renal Failure

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

Hyperkalemia, Pneumonia

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

MEDICAL CERTIFICATION

| | | | |
|--|--|--|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (X) (this hospital) attended the deceased from December 15, 19 86, to December 17, 19 86, that (X) (we) lost
saw the deceased alive on December 17, 19 86, and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated
above (X) (we) (did) (do) (do not) view the body after death. | | | |
| 22b. SIGNATURE
DARAB HORMOZI M.D. | DEGREE
M.D. | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED
12.18.86 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DARAB HORMOZI M.D. | | 22e. ADDRESS
c/o Maryland General Hospital | |

| | | | |
|--|-----------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
12-22-86 | 23c. NAME OF CEMETERY OR CREMATORY
Mt Zion | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore MD. |
| 24. FUNERAL DIRECTOR
NAME
Wm. C. Brown | | 25a. DATE REC'D. BY REGISTRAR
JAN 5 1987 | |
| ADDRESS
1206 W. North Ave | | 25b. REGISTRAR'S SIGNATURE
Julia Nelson-Rodgers | |

129230 JAN - 57

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0 3 4 5 7

REG. NO.

| | | | | | | | |
|---|--|--|--|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
ANN E. SIMPSON | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12-29-86 | | 2b. HOUR
MIN.
9⁰⁰ P M | | |
| 3. SEX
Female | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
12 21 33 | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS. MONTHS DAYS
53 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Charlotte Co. Va. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
3402 Edgewood Road | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
State of Maryland | | 12b. KIND OF BUSINESS OR INDUSTRY
Dept. of Resources | |
| 13a. STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Wilbert Thompson | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Lottie Venable | | 13e. STREET ADDRESS / ZIP CODE
3402 Edgewood Road | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
224-46-8470 | | 17. INFORMANT
ADDRESS
James E. Simpson 3402 Edgewood Rd. | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Generalized metastatic disease**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) **Carcinoma of the Anus**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

1 year**10 years**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

MEDICAL CERTIFICATION

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 64 to Dec 29 , 19 86 , that (I) (we) last saw the deceased alive on Dec 29 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Jay N. Karpas M.D. | | DEGREE
M.D. | | | | 22c. DATE SIGNED
12/31/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Jay N. Karpas, M.D. | | 22e. ADDRESS
1700 Reisterstown Rd. Pikesville Md. | | | | | |

| | | | | | | | |
|--|--|----------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
1-2-87 | | 23c. NAME OF CEMETERY OR CREMATORY
GARRISON FOREST | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto. Maryland | |
| 24. FUNERAL DIRECTOR
NAME
JAS. A. MORTON & SONS | | | | ADDRESS
1701 HANCOCKS ST. | | 25a. DATE REC'D. BY REGISTRAR
DEC 31 1986 | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE
Julia J. Simon-Rodriguez | |



[Faint, illegible handwriting covering the majority of the page, likely bleed-through from the reverse side.]

29083 JAN - 5 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

| | | | | | | | | | | | | | | | | | |
|---|---------|------------------------------|--|---|--|---|--|--------------------------------------|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH | | MONTH | | DAY | | YEAR | | 2b. HOUR | |
| Paul | | I. | | Singleton | | Jr. | | 12/26/1986 | | 12 | | 26 | | 1986 | | M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | MONTH | | DAY | | YEAR | |
| Male | Black | 8 20 44 | | 42 YRS. | | | | | | 12/26/1986 | | 12 | | 26 | | 1986 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | NEVER MARRIED | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Virginia | | U.S.A. | | WIDOWED | | DIVORCED | | Baltimore City, MD. | | Baltimore | | 827 N. Lakewood Ave. | | Disabled | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | 16b. SOCIAL SECURITY NO. | |
| Md | | | | Balt | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 835 N. Luzerne St 21205 | | N A | | N A | | NO | | 219-40-1888 | |
| 17. INFORMANT | | ADDRESS | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | | 21a. EXTERNAL CAUSE WAS | | 21b. TIME OF INJURY | |
| Geraldine Singleton | | 1513 N. Milton Ave | | PART 1 DEATH WAS CAUSED BY: | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | 21d. INJURY OCCURRED | |
| | | | | IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | |
| | | | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | 22a. I certify that I took charge of the remains described above, held an | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | |
| | | | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | death resulted from | | Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | |
| | | | | (c) | | | | | | | | | | 22b. I certify that I took charge of the remains described above, held an | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | |
| | | | | PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. | | | | | | | | | | 22c. I certify that I took charge of the remains described above, held an | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | |
| | | | | | | | | | | | | | | 22d. I certify that I took charge of the remains described above, held an | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | |
| | | | | | | | | | | | | | | 22e. I certify that I took charge of the remains described above, held an | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | |
| | | | | | | | | | | | | | | 22f. I certify that I took charge of the remains described above, held an | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | |
| | | | | | | | | | | | | | | 22g. I certify that I took charge of the remains described above, held an | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | |
| | | | | | | | | | | | | | | 22h. I certify that I took charge of the remains described above, held an | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | |
| | | | | | | | | | | | | | | 22i. I certify that I took charge of the remains described above, held an | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | |
| | | | | | | | | | | | | | | 22j. I certify that I took charge of the remains described above, held an | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | |
| | | | | | | | | | | | | | | 22k. I certify that I took charge of the remains described above, held an | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | |
| | | | | | | | | | | | | | | 22l. I certify that I took charge of the remains described above, held an | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | |
| | | | | | | | | | | | | | | 22m. I certify that I took charge of the remains described above, held an | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | |
| | | | | | | | | | | | | | | 22n. I certify that I took charge of the remains described above, held an | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | |
| | | | | | | | | | | | | | | 22o. I certify that I took charge of the remains described above, held an | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | |
| | | | | | | | | | | | | | | 22p. I certify that I took charge of the remains described above, held an | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | |
| | | | | | | | | | | | | | | 22q. I certify that I took charge of the remains described above, held an | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | |
| | | | | | | | | | | | | | | 22r. I certify that I took charge of the remains described above, held an | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | |
| | | | | | | | | | | | | | | 22s. I certify that I took charge of the remains described above, held an | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | |
| | | | | | | | | | | | | | | 22t. I certify that I took charge of the remains described above, held an | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | |
| | | | | | | | | | | | | | | 22u. I certify that I took charge of the remains described above, held an | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | |
| | | | | | | | | | | | | | | 22v. I certify that I took charge of the remains described above, held an | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | |
| | | | | | | | | | | | | | | 22w. I certify that I took charge of the remains described above, held an | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | |
| | | | | | | | | | | | | | | 22x. I certify that I took charge of the remains described above, held an | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | |
| | | | | | | | | | | | | | | 22y. I certify that I took charge of the remains described above, held an | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | |
| | | | | | | | | | | | | | | 22z. I certify that I took charge of the remains described above, held an | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | |
| | | | | | | | | | | | | | | 22aa. I certify that I took charge of the remains described above, held an | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | |
| | | | | | | | | | | | | | | 22ab. I certify that I took charge of the remains described above, held an | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | |
| | | | | | | | | | | | | | | 22ac. I certify that I took charge of the remains described above, held an | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | |
| | | | | | | | | | | | | | | 22ad. I certify that I took charge of the remains described above, held an | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | |
| | | | | | | | | | | | | | | 22ae. I certify that I took charge of the remains described above, held an | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | |
| | | | | | | | | | | | | | | 22af. I certify that I took charge of the remains described above, held an | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | |
| | | | | | | | | | | | | | | 22ag. I certify that I took charge of the remains described above, held an | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | |
| | | | | | | | | | | | | | | 22ah. I certify that I took charge of the remains described above, held an | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | |
| | | | | | | | | | | | | | | 22ai. I certify that I took charge of the remains described above, held an | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | |
| | | | | | | | | | | | | | | 22aj. I certify that I took charge of the remains described above, held an | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | |
| | | | | | | | | | | | | | | 22ak. I certify that I took charge of the remains described above, held an | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | |
| | | | | | | | | | | | | | | 22al. I certify that I took charge of the remains described above, held an | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | |
| | | | | | | | | | | | | | | 22am. I certify that I took charge of the remains described above, held an | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | |
| | | | | | | | | | | | | | | 22an. I certify that I took charge of the remains described above, held an | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | |
| | | | | | | | | | | | | | | 22ao. I certify that I took charge of the remains described above, held an | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | |
| | | | | | | | | | | | | | | 22ap. I certify that I took charge of the remains described above, held an | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | |
| | | | | | | | | | | | | | | 22aq. I certify that I took charge of the remains described above, held an | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | |
| | | | | | | | | | | | | | | 22ar. I certify that I took charge of the remains described above, held an | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | |
| | | | | | | | | | | | | | | 22as. I certify that I took charge of the remains described above, held an | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | |
| | | | | | | | | | | | | | | 22at. I certify that I took charge of the remains described above, held an | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | |
| | | | | | | | | | | | | | | 22au. I certify that I took charge of the remains described above, held an | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | |
| | | | | | | | | | | | | | | 22av. I certify that I took charge of the remains described above, held an | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | |
| | | | | | | | | | | | | | | 22aw. I certify that I took charge of the remains described above, held an | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | |
| | | | | | | | | | | | | | | 22ax. I certify that I took charge of the remains described above, held an | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | |
| | | | | | | | | | | | | | | 22ay. I certify that I took charge of the remains described above, held an | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | |
| | | | | | | | | | | | | | | 22az. I certify that I took charge of the remains described above, held an | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | |
| | | | | | | | | | | | | | | 22ba. I certify that I took charge of the remains described above, held an | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | |
| | | | | | | | | | | | | | | 22bb. I certify that I took charge of the remains described above, held an | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | |
| | | | | | | | | | | | | | | 22bc. I certify that I took charge of the remains described above, held an | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | |
| | | | | | | | | | | | | | | 22bd. I certify that I took charge of the remains described above, held an | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | |
| | | | | | | | | | | | | | | 22be. I certify that I took charge of the remains described above, held an | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | |
| | | | | | | | | | | | | | | 22bf. I certify that I took charge of the remains described above, held an | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | |
| | | | | | | | | | | | | | | 22bg. I certify that I took charge of the remains described above, held an | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | |
| | | | | | | | | | | | | | | 22bh. I certify that I took charge of the remains described above, held an | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | |
| | | | | | | | | | | | | | | 22bi. I certify that I took charge of the remains described above, held an | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | |
| | | | | | | | | | | | | | | 22bj. I certify that I took charge of the remains described above, held an | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | |
| | | | | | | | | | | | | | | 22bk. I certify that I took charge of the remains described above, held an | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | |
| | | | | | | | | | | | | | | 22bl. I certify that I took charge of the remains described above, held an | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | |
| | | | | | | | | | | | | | | 22bm. I certify that I took charge of the remains described above, held an | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | |
| | | | | | | | | | | | | | | 22bn. I certify that I took charge of the remains described above, held an | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | |
| | | | | | | | | | | | | | | 22bo. I certify that I took charge of the remains described above, held an | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | |
| | | | | | | | | | | | | | | 22bp. I certify that I took charge of the remains described above, held an | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | |
| | | | | | | | | | | | | | | 22bq. I certify that I took charge of the remains described above, held an | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | |
| | | | | | | | | | | | | | | 22br. I certify that I took charge of the remains described above, held an | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | |
| | | | | | | | | | | | | | | 22bs. I certify that I took charge of the remains described above, held an | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | |
| | | | | | | | | | | | | | | 22bt. I certify that I took charge of the remains described above, held an | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | |
| | | | | | | | | | | | | | | 22bu. I certify that I took charge of the remains described above, held an | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | |
| | | | | | | | | | | | | | | 22bv. I certify that I took charge of the remains described above, held an | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | |
| | | | | | | | | | | | | | | 22bw. I certify that I took charge of the remains described above, held an | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | |
| | | | | | | | | | | | | | | 22bx. I certify that I took charge of the remains described above, held an | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | |
| | | | | | | | | | | | | | | 22by. I certify that I took charge of the remains described above, held an | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | |
| | | | | | | | | | | | | | | 22bz. I certify that I took charge of the remains described above, held an | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | |
| | | | | | | | | | | | | | | 22ca. I certify that I took charge of the remains described above, held an | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | |
| | | | | | | | | | | | | | | 22cb. I certify that I took charge of the remains described above, held an | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | |
| | | | | | | | | | | | | | | 22cc. I certify that I took charge of the remains described above, held an | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | |
| | | | | | | | | | | | | | | 22cd. I certify that I took charge of the remains described above, held an | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | |
| | | | | | | | | | | | | | | | | | |

24 June 1972

028800 JAN 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|---------|---|--------------------------|---|--|-------------------------------|--|------------------|---|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | MONTH | DAY | YEAR | 2b. HOUR |
| ROBERT | | | | SINKLER | 12 | 22 | 86 | | 12 55 AM |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR | | IF UNDER 72 HRS. | | |
| M. | Black | 2 22 26 | | 60 | MONTHS | | DAYS | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | |
| S.C. | | USA | | | Baltimore city MD. | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Baltimore | | Liberty Medical Center | | | | | | | |
| 13a. STATE | | 13b. COUNTY | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS / ZIP CODE | | |
| MD | | | Baltimore | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | 917 Arlington Rd 21217 | | |
| 14. FATHER'S NAME | | MIDDLE | 15. MOTHER'S MAIDEN NAME | | ADDRESS | | | | |
| Hockler | | | Sarah Sinkler | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | | |
| NO | | 231-16-6058 | | Martha E. Sinkler 3002 Stranden Rd | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio respiratory arrest | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. a | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | |
| | | P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET | | CITY OR TOWN | | COUNTY | STATE |
| WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/22/86 to 1/27/86, that (I) (we) last saw the deceased alive on 1/22/86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | | | 22c. DATE SIGNED | |
| A. AGRAWAL | | | | MD | | | | 1/27/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | |
| A. AGRAWAL | | | | Liberty Med. Center | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN | | COUNTY | STATE |
| Burial | | 12/29/86 | | Cedar Hill Cemetery | | Anne Arundel | | Co | MD |
| 24. FUNERAL DIRECTOR
NAME | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Wm C. March Funeral Home | | | | 1101 E. North Ave | | DEC 30 1986 | | | |

MEDICAL CERTIFICATION

77
46
35
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove your signature. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | REG. NO. | |
|---|--|--|--|---|--|--|
| 1. FOR STATE REGISTRAR
DECEASED NAME (TYPE OR PRINT)
RAOUL A. SIOUI | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 / 12 / 86 | | 2b. HOUR
9:35 P.M. | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Nov. 21, 1910 | | 6. AGE (IN YEARS LAST BIRTHDAY)
76
YRS. MONTHS DAYS |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Canada | | 7b. CITIZEN OF WHAT COUNTRY?
Canada | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
City MD. |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
North Charles Gen. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Ret. Iron Worker | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
 Md. | | | 13b. COUNTY
 Baltimore | | 13c. CITY OR TOWN
 Baltimore | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
 Joseph Sioui | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
 Nathalie - | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
 no | | | 16b. SOCIAL SECURITY NO.
 216-24-0926 | | 17. INFORMANT ADDRESS
 Mrs. Alice L. Sioui Same | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
 8585 ACUTE MYOCARDIAL INFARCT
IMMEDIATE CAUSE (a)
DUE TO, OR AS A CONSEQUENCE OF
(b) THEOPHYLLINE TOXICITY
DUE TO, OR AS A CONSEQUENCE OF
(c) MULTIPLE CARDIAC ARRHYTHMIA
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).
 COPD. | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
 P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (I is hospital) attended the deceased from 12/9, 19 86 to 12/12, 19 86 , that (I) (we) last saw the deceased alive on 12/12, 19 86 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
 A.C. CHOUVALIT, M.D. | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>
 Approved by medical examiner 12/12/86 | | | | 22c. DATE SIGNED
 12/12/86 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
 A.C. CHOUVALIT, M.D. (For DR. WILLIAMS BOGG'S) | | | | 22e. ADDRESS
 North Charles General Hosp. | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
 Burial | | 23b. DATE
 Dec. 13, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY
 Parkwood | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
 Baltimore Md. |
| 24. FUNERAL DIRECTOR
 Leonard J. Ruck Inc. Baltimore, Maryland | | | | 25a. DATE REC'D. BY REGISTRAR
 15 1986 | | 25b. REGISTRAR'S SIGNATURE
 A. J. Henderson-Readner |

BP

26048 DEC -4 86

FOR
STATE
REGISTRAR

BLAT

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|---|---|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
BLANCHE C. SITES | | | 2a. DATE OF DEATH
MONTH DAY YEAR
DECEMBER 2 86 | | 2b. HOUR
1145 AM | | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
7-8-1906 | | 6. AGE (IN YEARS LAST BIRTHDAY)
80 YRS | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
S.D. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Balto. City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Balto. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Good Samaritan Hospital | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
Md. | | | | 13b. COUNTY | | 13c. CITY OR TOWN
Balto. | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Charles C. Hite | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Illie Knupp | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
214-09-9006 | | 17. INFORMANT
ADDRESS
Earl M. Sites, Same as 13c | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CEREBROVASCULAR ACCIDENT
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 month | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | | | |
| 19a. DATE OF OPERATION
- | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
- | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that 15 (this hospital) attended the deceased from 11/1/86 , 19 86 , to December 2 , 19 86 , that 4 (we) last saw the deceased alive on December 2 , 19 86 , and that in our (our) opinion death occurred on the date and hour and from the causes stated above, 4 (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Loutfi Aboussouan | | | DEGREE | | | 22c. DATE SIGNED
December 2, 86 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
LOUTFI ABOUSSOUAN | | | 22e. ADDRESS
GOOD SAMARITAN HOSPITAL
5601 LOCH RAVEN BLVD Baltimore | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
12-5-86 | | 23c. NAME OF CEMETERY OR CREMATORY
Edge Hill | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Charles Town. W.Va. | | |
| 24. FUNERAL DIRECTOR
NAME
Leonard J. Ruck, Inc., 5305 Harford Rd., Balto. | | | Md. | | 25a. DATE REC'D. BY REGISTRAR
DEC 3 1986 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the examiner must be signed at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it is completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon pages 1 and 2 and place them in the envelope provided with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. The funeral director must be signed at once.

BP _____

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

TO : DIRECTOR, FBI (100-441111)
FROM : SAC, NEW YORK (100-111111)
SUBJECT: [Illegible]

Re New York letter to Bureau dated 10/1/68.
Enclosed for the Bureau are two copies of a letterhead memorandum (LHM) dated and captioned as above.
The LHM is being furnished to the New York Office for its information.

Very truly yours,
[Illegible Signature]

Enclosure
100-441111
100-111111
100-111111

[Illegible text block]

[Illegible text block]

[Illegible text block]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by page 4.

MEDICAL CERTIFICATION

| FOR STATE REGISTRAR | | | | STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|---|--|--|--|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
FLORINE SLOAN | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
DECEMBER 18, 1986 | | | | 2b. HOUR
P
7:00 | | | |
| 3 SEX
female | | 4. RACE
black | | 5. DATE OF BIRTH
MONTH DAY YEAR
10 15 1919 | | 6. AGE (IN YEARS LAST BIRTHDAY)
67 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
7 18 00 | | IF UNDER 24 HRS.
HOURS MIN.
00 00 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
N.C. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE JOHNS HOPKINS HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Unemployed | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
Md | | | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
5318 Ethelbert Avenue 21215 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John Cureton | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mattie Cathy | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
220-76-1693 | | 17. INFORMANT
ADDRESS
Minnie Jackson 5318 Ethelbert Avenue | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory Arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) Esophageal cancer
DUE TO, OR AS A CONSEQUENCE OF
(c) Liver metastasis, Bowel obstruction | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
5 minutes
13 months | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | | | |
| 19a. DATE OF OPERATION
11/85 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Esophageal Cancer | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Nov 24 19 86 , to Dec 18 19 86 , that (I) (we) last saw the deceased alive on 7 PM Dec 18 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Sydney Yoon, MD | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED
12/18/86 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
SYDNEY YOON | | | | 22e. ADDRESS
Johns Hopkins Hosp | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
12/22/86 | | 23c. NAME OF CEMETERY OR CREMATORY
Eastview Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Md | | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
March Funeral Home West 4300 Wabash Avenue | | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 23 1986 | | 25b. REGISTRAR'S SIGNATURE
Julia Swenson-Randall | | | |

BP

1

WATER WORKS

029472 JAN-68

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

| | | | | | | | | | | | | | | | |
|---|---------|--|--|---|--|---|--|---|--|--------------------------|--|--|--|----------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH | | | | 2b. HOUR | | | |
| Coretha | | A. | | Smith | | DATE KNOWN OF DEATH | | | | 12 31 19 86 | | | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD | | | | 2d. HOUR | |
| F | B | 4 2 28 | | 58 YRS. | | MONTHS | | DAYS | | 19 | | | | M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | NEVER MARRIED | | WIDOWED | | DIVORCED | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Md | | USA | | MARRIED | | NEVER MARRIED | | WIDOWED | | DIVORCED | | Baltimore city | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | |
| Baltimore | | Union Memorial Hospital | | Housekeeper | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | | | |
| Md | | | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 2784 The Alameda | | | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | |
| Louis | | Ethel | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | | | |
| NO | | 218-22-2363 | | Mrs Dreece Green | | 1322 N. Bentlon | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) CARDIAC ARREST | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. | | | | | | | | | | | | | | | |
| (b) H. C. V. D. | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? | | | |
| | | | | | | | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| | | | | P.M. 19 | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | TITLE (SPECIFY) | | | | | | | | DATE SIGNED | | | |
| Y.R. Sadzadi | | | | M.D. | | | | | | | | 1-3-87 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS | | | | | | | | | | | |
| | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| Burial | | | | 1/5/87 | | | | Saint Rest Cemetery | | | | Hanover Md | | | |
| 24. FUNERAL DIRECTOR NAME | | | | ADDRESS | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | |
| Wm C. March F.H. | | | | 1101 E. North Avenue | | | | JAN 5 1987 | | | | Julia Division-Randall | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 48 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGE 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSITMENT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
35M

BP
DHMH - 17
(VR A15 ME (5))

028286 DEC 20 1986

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
David Smith | | | 2a. DATE OF DEATH
MONTH DAY YEAR
December 18, 1986 | | | 2b. HOUR
M | | | |
| 3. SEX
Male | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
3 15 18 | | 6. AGE (IN YEARS LAST BIRTHDAY)
68 YRS | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE City MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
702 East Chase St. 1st Floor | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
UNEMP. | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
702 E. CHASE ST. 1st. fl. 21202 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
DAVID C. SMITH, SR. | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
UNK | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
218057913 | | 17. INFORMANT ADDRESS
IRENE SMITH 2520 RIDGELY ST. 21230 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Asystolic - ventricular tachycardia</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost
saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<i>Dr. C. C. Smith</i> | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
McCawley D | | | | 22e. ADDRESS
1000 E. Fager St Bldg 11/21/201 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
BURIAL | | 23b. DATE
12-27-86 | | 23c. NAME OF CEMETERY OR CREMATORY
MT. ZION CEMETERY | | 23d. LOCATION
BALTO. COUNTY MD | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
March Funeral Homes 1101 East North Avenue | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 24 1986 | | 25b. REGISTRAR'S SIGNATURE
<i>John T. ...</i> | | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return remaining pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other unusual event, the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please send this certificate to the Division of Vital Records, Department of Health and Mental Hygiene, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | | |
|--|--|---|--|--|---|--|---|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | | | | |
| 2. DECEASED NAME
(TYPE OR PRINT)
Eleanor Smith | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 29 86 | | | | | 2b. HOUR
1230 PM | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
4 21 1934 | | | 6. AGE (IN YEARS LAST BIRTHDAY)
52 YRS. | | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
South Baltimore General Hospital | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | | 12b. KIND OF BUSINESS OR INDUSTRY
own home | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE NO 13b. COUNTY Baltimore 13c. CITY OR TOWN Baltimore | | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
3604 Lilac Avenue 21227 | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Williams Nussan | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Giles | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | | | | 16b. SOCIAL SECURITY NO.
219-30-4896 | | 17. INFORMANT
Charles Smith 3604 Lilac Avenue | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardio Respiratory Arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Advanced Bronchogenic Carcinoma</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Dx 4/86 | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>December 26</u> , 19 <u>86</u> , to <u>December 29</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>December 29</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>John A. Tygart</u> | | | | | DEGREE
MD
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED
12/29/86 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
John A. Tygart | | | | | 22e. ADDRESS
South Balt Gen Hospital | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | 23b. DATE
01/02/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Meadowridge Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Dorsey Howard Md. | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Ambrose Funeral Home 1328 Sulphur Spring Rd. | | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 30 1986 | | 25b. REGISTRAR'S SIGNATURE
<u>Julia Seidman-Randall</u> | | | |

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|-----|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 | 32 | 33 | 34 | 35 | 36 | 37 | 38 | 39 | 40 | 41 | 42 | 43 | 44 | 45 | 46 | 47 | 48 | 49 | 50 | 51 | 52 | 53 | 54 | 55 | 56 | 57 | 58 | 59 | 60 | 61 | 62 | 63 | 64 | 65 | 66 | 67 | 68 | 69 | 70 | 71 | 72 | 73 | 74 | 75 | 76 | 77 | 78 | 79 | 80 | 81 | 82 | 83 | 84 | 85 | 86 | 87 | 88 | 89 | 90 | 91 | 92 | 93 | 94 | 95 | 96 | 97 | 98 | 99 | 100 |
|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|-----|

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 3 4 9 0 0

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | | |
|--|--|---|--|---|--|---|--|--|--|--|--|
| DECEASED NAME
(TYPE OR PRINT)
EVAN | | FIRST
SMITH | | LAST
(Wilson) | | 2a. DATE OF DEATH
MONTH DAY YEAR
12/3/86 | | | | 2b. HOUR
1130 P M | |
| 3. SEX
Male | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
09 15 30 | | 6. AGE (IN YEARS LAST BIRTHDAY)
56 YRS. | | | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
N.C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Sinai Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Disabled | | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | 13e. STREET ADDRESS
21209
4800 Yellowwood Ave. Apt 119 | | | | | |
| 13a. STATE
MD | | 13b. COUNTY | | 13c. CITY OR TOWN
City | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Ben | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Rosetta Hamrick | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
216-26-7680 | | 17. INFORMANT
ADDRESS
Alice Leak Smith 4800 Yellowwood Ave | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Lymphoma</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/1</u> , 19 <u>86</u> , to <u>12/3</u> , 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>12/3</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
DEGREE
Denise Cook, M.D. | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL STAFF <input checked="" type="checkbox"/> HOUSE PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED
12/3/86 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Denise COOK, MD | | | | 22e. ADDRESS
Belvedere + Greenburg | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
Burial | | 23b. DATE
12/9/86 | | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park Cemetery | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Maryland | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
March Funeral Home West 4300 Wabash Avenue | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 10 1986 | | 25b. REGISTRAR'S SIGNATURE | | | | | |

MEDICAL CERTIFICATION

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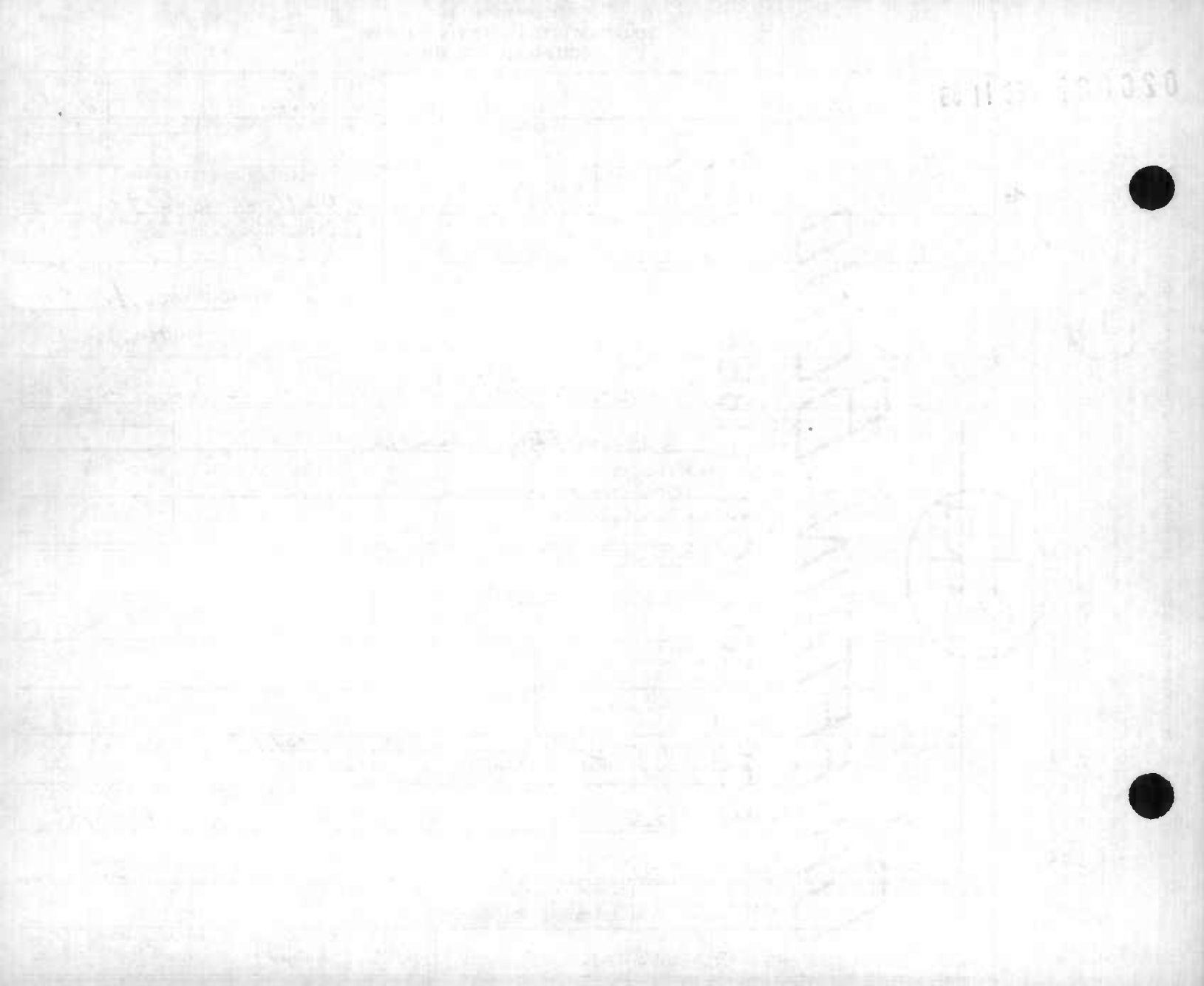
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and approved by the health officer, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT SERVICE, AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR MOVEMENT.

| | | | | | | | | | |
|--|--|---|--|--|--|--|--|---------------------------|--|
| DECEASED NAME
(TYPE OR PRINT) | | George G. Smith | | 2a. DATE KNOWN OF DEATH | | <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR | | 2b. HOUR | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | 7. IF UNDER 1 YR. | |
| male | | black | | 3 DAY 20 1952 | | 34 YRS. | | IF UNDER 24 HRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | 2c. DATE PRONOUNCED DEAD | |
| S. C. | | USA | | | | Baltimore City, | | 12-2 1986 | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | 2d. HOUR | |
| Baltimore | | South Baltimore General Hospital | | Laborer | | Cleaners | | 4:51 p.m. | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | |
| Md | | | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 5925 Charnwood Road 21228 | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| George | | Elma | | Yes | | 224-70-9887 | | Sadie Bradley | |
| | | | | (IF YES, GIVE WAR OR DATES) | | | | ADDRESS | |
| | | | | | | | | 5925 Charnwood Road | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 1 DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) Narcotism | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. | | | | | | | | | |
| (b) | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | | | | | |
| | | | | Yes <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR Primary CONTRIBUTING CAUSE OF DEATH | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| | | ? P.M. 12 2 1986 | | Subject used drug | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | | | | | |
| | | home | | 5920 Charwood Road, Baltimore, Md. | | | | | |
| 22a. I certify that I took charge of the remains described above, held an | | Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | |
| death resulted from | | Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | MEDICAL EXAMINER | | DATE SIGNED | | | |
| Dennis F. Smyth, M.D. | | Assistant | | | | 12-3-86 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | | | | | | |
| Dennis F. Smyth, M.D. | | 111 Penn St., Balto., Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | |
| Burial | | 12/6/86 | | Garrison Forest Vet | | Owings Mills | | | |
| 24. FUNERAL DIRECTOR NAME | | ADDRESS | | 25a. DATE REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| March Funeral Home | | West 4300 Wabash Avenue | | DEC 5 1986 | | Dennis F. Smyth | | | |

1914-15

1914-15



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | |
|---|------------------|--|--|---|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Jennifer R. Smith | | | 2a. DATE KNOWN OF DEATH
MONTH DAY YEAR
12 15 19 86 | | | 2b. HOUR
M
12 15 19 86 | | |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
March 11, 1967 | 6. AGE (IN YEARS)
(LAST BIRTHDAY)
19 YRS. | 7. IF UNDER 1 YR.
MONTHS DAYS HOURS MIN | 7c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
12 15 19 86 | 2d. HOUR
M
2:31P | | |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD. | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
St. Agnes Hospital | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Receptionist | | 12b. KIND OF BUSINESS OR INDUSTRY
- KVT Lyon Co. | |
| 13a. STATE
Maryland | | 13b. CITY OR TOWN
Catonsville | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
402 Bathurst Road 21228 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Kermit Ray Smith | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Peggy Bledsoe | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
217-02-3026 | | 17. INFORMANT
Kermit R. Smith
ADDRESS
402 Bathurst Road
Catonsville, MD. 21228 | | | | |

| | | |
|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute cardiac failure</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|--|--|

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

| | | | | | |
|--|--|---|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |

| | | | | | |
|---|--|------------------------------------|--|-------------------------|--|
| 22a. I certify that I took charge of the remains described above, held an <u>Autopsy</u> <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | |
| ACTUAL SIGNATURE
<i>William M. Zane</i> | | TITLE (SPECIFY)
Assistant | | DATE SIGNED
12/16/86 | |
| EXAMINER'S NAME
(TYPE OR PRINT)
William M. Zane, M.D. | | ADDRESS
111 Penn St. Balto. MD. | | | |

| | | | | | | | |
|--|--|-----------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
12/18/86 | | 23c. NAME OF CEMETERY OR CREMATORY
Crestlawn Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Marriottsville Maryland | |
| 24. FUNERAL DIRECTOR
Leroy M. & Russell C. Witzke Funeral Homes P.A.
1630 Edmondson Avenue, Catonsville, MD. 21228 | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 18 1986 | | 25b. REGISTRAR'S SIGNATURE
<i>W. Anderson-Landauer</i> | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN BLOCK IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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057 10 10 10



029363 JAN - 6 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|--|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Joseph Martin SMITH | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12/31/86 | | 2b. HOUR
645PM |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
3 10 16 | | 6. AGE (IN YEARS (LAST BIRTHDAY))
70 YRS. | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
F.S. Key Medical Center | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | 12b. KIND OF BUSINESS OR INDUSTRY
Pemco Corp. | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md. | | 13b. COUNTY
Baltimore | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS, ZIP CODE
6816 Conley Street 21224 |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Arthur | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Theresa Tarr | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
W.W. 2
213-12-9309 | 17. INFORMANT ADDRESS
Rita A. Kromeke 1381 Algodones Ct. S.E. N.M. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardio respiratory Arrest</u> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Infection</u> | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Chronic Respiratory Insufficiency</u> | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE FORMAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Severe Restrictive Lung Disease, Congestive Heart Failure</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10/21/86</u> , 19 <u>86</u> , to <u>12/31</u> , 19 <u>86</u> , that (I) (we) lost
saw the deceased alive on <u>12/31</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>Laura Marx</u> | | 22c. DATE SIGNED
<u>12/31/86</u> | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
LAURA MARX | |
| 22e. ADDRESS
PSMCC 4940 EASTERN AVE. | | 22f. ADDRESS
PSMCC 4940 EASTERN AVE. | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
1-03-87 | 23c. NAME OF CEMETERY OR CREMATORY
New Cathedral Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore City Md. |
| 24. FUNERAL DIRECTOR
NAME
Charles S. Zeiler & Son Inc. | | ADDRESS
6224 Eastern Ave. | | 25a. DATE REC'D. BY REGISTRAR
JAN 5 1987 | |
| 25b. REGISTRAR'S SIGNATURE
<u>L. A. Anderson</u> | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

100-100000

100-100000

**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO.

FOR
1- STATE
REGISTRAR

| | | | | | | | | | | | | | |
|--|---------|--|--|---|----------------|------------------------------------|-------------------------|---|--------------------------|---|----------|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST (LEON) | | MIDDLE (M.) | LAST (SMITH) | | 2a. DATE KNOWN OF DEATH | | XX MONTH DAY YEAR | | 2b. HOUR | | |
| Kadmiel | | Musa | | Pratabulu-Bey | | 12-20 1986 | | | | 1:04 p.m. | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | 24 HOUR | | |
| M | B | 1 23 50 | | 36 YRS. | | | | | 12-20 1986 | | | | |
| 8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | NEVER MARRIED | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| MD | | USA | | YES | | WIDOWED | | Baltimore City, | | MD | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| Baltimore | | 414 E. 21st Street, 2nd floor | | CASE WORKER | | SOCIAL SERV. | | | | | | | |
| 13a. STATE | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | |
| MD | | | | | | BALTO. | | YES | | 414 E. 21st. STREET 21218 | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | |
| FIRST MIDDLE LAST | | | | FIRST MIDDLE LAST | | | | | | | | | |
| MOSES LEROY SMITH | | | | CLEO ROYSTER | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | |
| YES | | | | 212485707 | | CLEO SMITH | | 2102 BOONE STREET 21218 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Gunshot Wound of Chest (unspecified) | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? | | | |
| | | | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| | | | | 12:45 PM 12-20 1986 | | | | subject was shot | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION | | | | | |
| | | | | Home | | | | 414 E. 21st St., 2nd fl., Baltimore, Maryland | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | TITLE (SPECIFY) | | | | DATE SIGNED | | | | | |
| | | | | M.D. Assistant | | | | 12-21-86 | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS | | | | | | | | | |
| William M. Zane, M.D. | | | | 111 Penn St., Balto., Md. | | | | 21201 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION | | | |
| BURIAL | | | | 12 24 86 | | GARRISON FOREST | | | | OWINGS MILLS | | | |
| 24. FUNERAL DIRECTOR | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| MARCH FUNERAL HOME | | | | 1101 E. NORTH AVE. | | | | DEC 23 1986 | | | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSFER PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25M

BP
DHMH - 17
(VR A15 ME (5))

029120 JAN -5

17 FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|---|---|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
MARIE ROSE SMITH | | | 2a. DATE OF DEATH MONTH DAY YEAR
12 29 86 | | 2b. HOUR MIN
11 AM | | | | |
| 3 SEX
FEMALE | | 4 RACE
WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR
12 06 16 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.
70 | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
JOHN L. DEATON HOSPITAL | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOMEMAKER | | 12b. KIND OF BUSINESS OR INDUSTRY
HOME | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE 13b. COUNTY 13c. CITY OR TOWN
MARYLAND ANNE ARUND. PASADENA | | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
7772 OUTING AVE. 21122 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
ALFRED KELLY | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
ELIZABETH BOSSE | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | | | | |
| 16b. SOCIAL SECURITY NO.
213 01 2822 | | 17. INFORMANT ADDRESS
ELIZABETH O'LEARY PASADENA, MD 21122 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST
DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC COLON CARCINOMA
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/29 19 86 to 12/29 19 86 , that (I) (we) (we) saw the deceased alive on 12/29 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
G.A. Harper, MD | | | DEGREE | | | 22c. DATE SIGNED
12/29/86 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
GAYLE A. HARPER, MD | | | 22e. ADDRESS
DEATON MEDICAL CENTER, BALTIMORE, MD | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
CREMATION | | | 23b. DATE
JAN. 2, 1987 | | 23c. NAME OF CEMETERY OR CREMATORY
SECURITY PROCESS, INC | | 23d. LOCATION CITY OR TOWN COUNTY STATE
CATONSVILLE BALTIMORE MD | | |
| 24. FUNERAL DIRECTOR NAME
McCULLY F.H. OF PASADENA | | | 24b. ADDRESS
PASADENA, MD 21122 | | 25a. DATE REC'D. BY REGISTRAR
JAN 2 1987 | | 25b. REGISTRAR'S SIGNATURE
Julia Gordon-Randall | | |

MEDICAL CERTIFICATION

9
9

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, a death certificate must be filed with the medical examiner's report.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

027652 DEC 19 1986

FOR
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | |
|---|--|---|---|--|---------------------------|--|
| 1 DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Mary M. Smith | | | 2a DATE OF DEATH
MONTH DAY YEAR
12-15-86 | | 2b HOUR
3:50 PM | |
| 3 SEX
Female | | 4 RACE
White | | 5 DATE OF BIRTH
MONTH DAY YEAR
3 29 08 | | 6 AGE (IN YEARS LAST BIRTHDAY)
78 YRS. |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b CITIZEN OF WHAT COUNTRY?
USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. |
| 10 CITY OR TOWN OF DEATH
Baltimore | | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Seton Hill Manor | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b KIND OF BUSINESS OR INDUSTRY |
| 13a STATE
Maryland | | 13b COUNTY
-- | | 13c CITY OR TOWN
Baltimore | | 13d INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
(unknown) | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
(unknown) | | 13e STREET ADDRESS / ZIP CODE
510 West 27th Street 21211 | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
213-282-511 | | 17 INFORMANT
ADDRESS
Philbert Myers 510 West 27th Street 21211
Seton Hill Records | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Cardiovascular Failure
DUE TO, OR AS A CONSEQUENCE OF
(b) Frequent Aspiration Pneumonia
DUE TO, OR AS A CONSEQUENCE OF
(c) 3 mo.
Approximate interval between onset and death: 10 min. | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) | | | | | | |
| 19a DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a I certify that (I) (this hospital) attended the deceased from 7/12 , 19 86 , to 12/15 , 19 86 , that (I) (we) last saw the deceased alive on 12/15 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) relied solely upon the body after death. | | | | | | |
| 22b. SIGNATURE
Jaime Ponzalan | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12/16/86 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JAIME PONZALAN | | 22e. ADDRESS
5214 Harford Rd. Balt. Md. 21214 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
12/19/86 | | 23c. NAME OF CEMETERY OR CREMATORY
Lakeview Memorial Pk. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Sykesville Maryland |
| 24 FUNERAL DIRECTOR
NAME ADDRESS
A. Alan Seitz, Jr. 3818 Roland Ave. 21211 | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 17 1986 | | 25b. REGISTRAR'S SIGNATURE
[Signature] |

MEDICAL CERTIFICATION

9
9

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filed by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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|---|--|---|--|--|---|---|---------|--|--|--|--|
| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 86 34973 | |
| FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
MCKINLEY SMITH | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
DEC 10 1986 | | | 2b. HOUR
1:50A M | | | |
| 3. SEX
M | | 4. RACE
B | | 5. DATE OF BIRTH
MONTH DAY YEAR
4 29 23 | | 6. AGE (IN YEARS LAST BIRTHDAY)
63 YRS | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
W. Carolina | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Balt. City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
? | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
LIBERTY MED CTR | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
? | | 12b. KIND OF BUSINESS OR INDUSTRY
? | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE
MO | | 13b. COUNTY
DALE | | 13c. CITY OR TOWN
DALE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
1232 1/2 St. 21220 | | | |
| 14. FATHER'S NAME
FIRST ? MIDDLE ? LAST ? | | | | | 15. MOTHER'S MAIDEN NAME
FIRST ? MIDDLE ? LAST ? | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
? | | | 16b. SOCIAL SECURITY NO.
226-247509 | | 17. INFORMANT
chart | | ADDRESS | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>card arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>sepsis</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>esophageal ca</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
15'
20 days
? | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>DEC 7</u> , 19 <u>86</u> , to <u>DEC 10</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>DEC 10</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Andrew Weinstein, MD | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED
12/10/86 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Andrew Weinstein, MD | | | | 22e. ADDRESS
Liberty Medical Center, Balt, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL | | | | 23b. DATE
12/15/86 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Auburn Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | |
| 24. FUNERAL DIRECTOR
C. Carroll | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 15 1986 | | | | 25b. REGISTRAR'S SIGNATURE
Julia Gordon-Rodriguez | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 3 4 7 4

1 - FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|--|--|--|--|--|
| 1 DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
Nobor J. Smith | | | 2a. DATE OF DEATH MONTH DAY YEAR
12 24 86 | | 2b. HOUR
8:25 AM |
| 3 SEX
Male | 4 RACE
Black | 5 DATE OF BIRTH MONTH DAY YEAR
03 07 24 | 6 AGE (IN YEARS LAST BIRTHDAY)
62 YRS | IF UNDER 1 YEAR
MONTHS DAYS
9 14 | IF UNDER 24 HRS
HOURS MIN.
14 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
U.S.A. | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | |
| 10 CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Mt. Vernon Care Center | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Laborer | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md. | | | 13b. COUNTY | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Unkn | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE
Unkn | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
Unknown | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)
216-58-2371 | 17 INFORMANT ADDRESS
Larry D. Smith 1807 E. 30th Street | | | |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>PATIENT'S CAUSE OF DEATH</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>POSSIBLE MI</u>
DUE TO, OR AS A CONSEQUENCE OF (c)
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <u>A. Chattejee</u> DEGREE <u>MD</u> | | | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
A. CHATTERJEE | | | | 22e. ADDRESS
MT VERNON NURSING HOME | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | 23b. DATE
12/31/86 | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Zion Cemetery | 23d. LOCATION CITY OR TOWN
Baltimore | COUNTY | STATE
MD |
| 24. FUNERAL DIRECTOR NAME
March Funeral Home 1101 E. North Avenue | | | 25a. DATE REC'D. BY REGISTRAR
DEC 30 1986 | | |
| | | | 25b. REGISTRAR'S SIGNATURE
Julia Tindon-Randall | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial. IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

| | | | | | |
|---|--|---|---|--|---|
| DECEASED NAME
(TYPE OR PRINT)
Pauline Caroline Smith | | | 2a. DATE OF DEATH
MONTH DAY YEAR
Dec. 16, 1986 | | 7b. HOUR
5:00 ^A _M |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
July 10 1907 | 6. AGE (IN YEARS LAST BIRTHDAY)
79 YRS | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
604 N. Curley St. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Telephone Operator | 12b. KIND OF BUSINESS OR INDUSTRY
C. & P. | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md. | 13b. COUNTY | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
604 N. Curley St. 21205 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Anton Sadler | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ida Klarnar | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
219-05-7239 | 17. INFORMANT
ADDRESS
Robert Smith (son) 1811 Arabian Way
Fallston, Md. 2104 | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>ASCVD</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Hypertension</u> | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9/9</u> , 19 <u>77</u> , to <u>12/16</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>12/12</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>Dr. Larocco</u> | | DEGREE
<u>MD</u> | | 22c. DATE SIGNED
<u>12/17/86</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Dr. Larocco | | 22e. ADDRESS
7600 Osler Dr. | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
12/19/86 | 23c. NAME OF CEMETERY OR CREMATORY
Baltimore | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Md. | | |
| 24. FUNERAL DIRECTOR
NAME
Schimunek Funeral Home, Inc.
3331 Brehms Lane, Balto. Md. 21213 | | 25a. DATE REC'D. BY REGISTRAR
DEC 19 1986 | | 25b. REGISTRAR'S SIGNATURE
<u>Julia Anderson-Bridner</u> | |

LIBRARY

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|---|----------------------|---|--|---|--------------------------------|---|--|--|--|--|-------------------|
| 1. DECEASED NAME
(TYPE OR PRINT) VERLINDA G. SMITH | | | | | | | | | | 2a. DATE KNOWN OF DEATH ESTI- MATED <input checked="" type="checkbox"/> 12-9-86 19 | 2b. HOUR M |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH
MONTH DAY YEAR June 28, 1902 | 6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS. | IF UNDER 1 YR.
MONTHS DAYS | IF UNDER 24 HRS.
HOURS MIN. | 7c. DATE PRONOUNCED DEAD 12-12-86 19 | 7d. HOUR 10:53a | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 301 McMeheh St. Apt. 523 | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Manacurist Lord Balto. Hotel | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE Md. | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 301 McMechen Street 21217 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST Aylmer Garrison | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST Mary Burner | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Dr. Mr. Irving A. Garrison Sr. 3018 Parkside | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>Margarita A. Korell</i> | | | | TITLE (SPECIFY) Assistant MEDICAL EXAMINER | | | | DATE SIGNED 12-12-86 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. | | | | ADDRESS 111 Penn Street | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE Dec. 15, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY Westview Memorial | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE Catonsville Balto. Md. | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS Leonard J. Ruck Inc. Baltimore, Maryland | | | | | | 25a. DATE REC'D. BY REGISTRAR DEC 15 1986 | | 25b. REGISTRAR'S SIGNATURE <i>Julia Tidson-Randall</i> | | | |

026452 DEC

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | |
|---|--|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
WILLIAM SMITH | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 04 86 | | 2b. HOUR
11 50 PM | |
| 3. SEX
M | | 4. RACE
BLK | | 5. DATE OF BIRTH
MONTH DAY YEAR
02/27/1900 | | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
N.C. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 6. AGE (IN YEARS LAST BIRTHDAY)
86 YRS. | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Sinai Hospital | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALT CITY MD. | | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | | 12b. KIND OF BUSINESS OR INDUSTRY
Swift Heat | | 21215 | | |
| 13a. STATE
Md | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Daniel Smith | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Rebecca Whitehead | | 13d. STREET ADDRESS / ZIP CODE
2907 Oakley Ave | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
148-09-6349 | | 17. INFORMANT
ADDRESS
Paulette Haden 2907 Oakley Ave | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST
DUE TO, OR AS A CONSEQUENCE OF (b) UGI BLEED
DUE TO, OR AS A CONSEQUENCE OF (c) CHRONIC INFECTION
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 HR
3 WKS | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a
SACRAL DECUBITUS, CHF | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/18 , 19 86 , to 12/5 , 19 86 , that (I) (we) last saw the deceased alive on 12/4 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (I) did not view the body after death. | | | | | | |
| 22b. SIGNATURE
Richard J. Segal | | DEGREE
MD | | 22c. DATE SIGNED
12/5/86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
RICHARD J. SEGAL | | 22e. ADDRESS
SINAI HOSP OF BALT. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
12/10/86 | | 23c. NAME OF CEMETERY OR CREMATORY
Arbutus Memorial Park | | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Arbutus Md | | 23e. DATE REC'D. BY REGISTRAR
DEC 8 1986 | | 23f. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
March Funeral Home West 4300 Wabash Avenue | | | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that a death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial transit permit. Then please show carbon papers. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|---|---|--|--|---------------------|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
JAMES H. SMOOT | | | 2a. DATE OF DEATH MONTH DAY YEAR
12/29/86 | | 2b. HOUR
1:04 PM |
| 3. SEX
male | 4. RACE
Blk | 5. DATE OF BIRTH
MONTH DAY YEAR
61-09-01 | 6. AGE (IN YEARS LAST BIRTHDAY)
85
YRS. | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Washington, D.C. USA | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
City MD. | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Liberty Medical Center | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
District of Columbia | | 13b. COUNTY
Washington | 13c. CITY OR TOWN
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13d. STREET ADDRESS / ZIP CODE
4122 Lane Place, N.E. 99999 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
James A. Smoot | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary A. Peyton | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
577 60 1741 | 17. INFORMANT ADDRESS
Roland T. Smoot-son-3817 Copley Road
Baltimore, Maryland | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) METASTATIC CORN OF PROSTATE
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b)
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY
(AT HOME STREET FACTORY OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
LUDWIG L. CUATO | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED
12/29/86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
LUDWIG L. CUATO | | 22e. ADDRESS
LIBERTY MEDICAL CENTER | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
Jan. 3, 1987 | 23c. NAME OF CEMETERY OR CREMATORY
Lincoln Memorial Cemetery | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Suitland, Md. | | |
| 24. FUNERAL DIRECTOR
(NAME)
Stewart | | 25a. DATE REC'D. BY REGISTRAR
JAN 7 1987 | | 25b. REGISTRAR'S SIGNATURE
Julia Brown-Rodriguez | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial-transit. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trauma, or event, the medical examiner must be notified at once.

BP

999999
DHMH - 16 6097/84
(VRA 15, 1)

RECEIVED
JAN 11 1964
U.S. AIR FORCE
HEADQUARTERS
AIR FORCE
WASHINGTON, D.C.

TO: DIRECTOR, AIR FORCE

FROM: SAC, NEW YORK

SUBJECT: [illegible]

RE: [illegible]

DATE: [illegible]

CLASS: [illegible]

STATUS: [illegible]

REMARKS: [illegible]

ADMINISTRATIVE: [illegible]

OTHER: [illegible]

APPROVED: [illegible]

SPECIAL AGENT IN CHARGE

[illegible]

[illegible]

[illegible]

027772

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 3 4 7 7 9

REG. NO.

| | | | | | | | | |
|--|---|---|--------------------------------------|--|--|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| FIRST MIDDLE LAST
William G. Smuck Sr Smuck | | | MONTH DAY YEAR
12 11 86 | | | 1:12 pm | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE | | | 7. IF UNDER 1 YEAR | | |
| Male | White | MONTH DAY YEAR
August 19, 1917 | 69 YRS. | | | MONTHS DAYS HOURS MIN. | | |
| 8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 8b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Maryland | U.S.A. | | Baltimore MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Baltimore | St. Agnes Hospital | | | Retired Newspaper delivery | | | | |
| 13a. STATE | | | 13b. CITY OR TOWN | | | 13c. STREET ADDRESS / ZIP CODE | | |
| Maryland | | | Baltimore | | | 2818 Rockwell Ave., 21228 | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | |
| FIRST MIDDLE LAST
John Smuck | | | FIRST MIDDLE LAST
Mary O'Brien | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT ADDRESS | | |
| No | | | 213 12 4615 | | | 21104 M's Susan Rippel 7312 Ridge Rd Marriottsville | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY COLLAPSE</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>SEVERE OBSTRUCTIVE VASCULAR DISEASE</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>LABYRINTHIC GYROSIS</u> | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | | | | |
| | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/29</u> , 19 <u>86</u> , to <u>12/11</u> , 19 <u>86</u> that (I) <u>me</u> last saw the deceased alive on <u>12/11</u> , 19 <u>86</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>me</u> (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | | 22c. DATE SIGNED | |
| <u>E. KASATIS, MD</u> | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 12/11/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | |
| E. KASATIS, MD | | | | BALTIMORE, MD 21228 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) <u>BURIAL</u> | | 23b. DATE
<u>Dec. 15'86</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Crestlawn</u> | | 23d. LOCATION
CITY OR TOWN STATE
<u>Howard Maryland</u> | | |
| 24. FUNERAL DIRECTOR
NAME | | | | 25a. DATE REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| Harry H Witzke & Family Funeral Home
Inc 4112 Old Columbia Pike Ellicott City | | | | DEC 18 1986 | | <u>John W. Witzke</u> | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corner papers. Pages 1 and 2 should be filed with 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

| | | | | | | | | | | | |
|---|--|----------------------|--|---|--|---|--|---|--|---|--|
| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
| 1. DECEASED NAME
(TYPE OR PRINT) Barbara Helena Soellner | | | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH 12 DAY 7 YEAR 1986 | | | | 2b. HOUR M | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH
MONTH 8 DAY 5 YEAR 1912 | | 6. AGE (IN YEARS)
(LAST BIRTHDAY) 74 YRS. | | 7c. DATE PRONOUNCED DEAD
MONTH 12 DAY 7 YEAR 1986 | | 7d. HOUR 9:40 M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Good Samaritan Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Maryland | | | | 13b. COUNTY Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13c. STREET ADDRESS 1911 Burnwood Rd., 21239 | | | |
| 14. FATHER'S NAME
FIRST John MIDDLE LAST May | | | | 15. MOTHER'S MAIDEN NAME
FIRST Catherine MIDDLE LAST Stuebin | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. 215-05-6493 | | 17. INFORMANT ADDRESS John G. Soellner, 5624 Laurelton Ave. 21214 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease and
XXXXXXXXXXXXXXXXXXXX
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. XX Chronic obstructive pulmonary disease
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion | | | | | | | | | | | |
| ACTUAL SIGNATURE Margarita A. Korell | | | | TITLE (SPECIFY) Assistant | | | | DATE SIGNED 12/7/86 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. | | | | ADDRESS 111 Penn St. Balto.MD. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 12-10-86 | | 23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer | | 23d. LOCATION
CITY OR TOWN COUNTY STATE Balto., Md. | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS Leonard J. Ruck, Inc., 5305 Harford Rd. | | | | | | 25a. DATE REC'D. BY REGISTRAR DEC 8 1986 | | 25b. REGISTRAR'S SIGNATURE Julia Davidson-Pandora | | | |

038261 6-10-55

10-10-55
J. L. L.

Homestead
10-10-55

John A. Sullivan, 2024
Gaiterline
10-10-55



RECEIVED

10-10-55

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | |
|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME (PRINT) | | 2a. DATE OF DEATH MONTH DAY YEAR | |
| 29 | | CHARLES (SOMERVILLE) | | DECEMBER 19, 1986 | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | |
| Male | | Black | | 8 17 33 | |
| 6. AGE (IN YEARS LAST BIRTHDAY) | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| 53 | | | | BALTIMORE CITY MD. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| N.C. | | U.S.A. | | Laundry Work | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| BALTIMORE | | THE JOHNS HOPKINS HOSPITAL | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. INSIDE CITY LIMITS? | |
| Maryland | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | 13d. STREET ADDRESS / ZIP CODE | |
| James Somerville | | Dora Bell | | 1611 Lewellyn Ave..21213 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | | 17. INFORMANT ADDRESS | |
| No | | 246-46-4210 | | Charles H. Somerville 1611 Lewellyn Ave, Balto., Md | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) LUNG CANCER | | | | | one year |
| DUE TO, OR AS A CONSEQUENCE OF (b) | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| | | P.M. 19 | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE | |
| | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/19, 19 86, to 12/19, 19 86, that (I) (we) last saw the deceased alive on 12/19, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death. | | | | | |
| 22b. SIGNATURE DEGREE | | | | 22c. DATE SIGNED | |
| Daniel L. Clemens, MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 12/19/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | |
| Dr. Victor Marcial Vega | | | | THE JOHNS HOPKINS HOSPITAL 600 N. Wolfe St. BALTO. MD. 21205 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 12-24-86 | | Eastview | |
| 24. FUNERAL DIRECTOR NAME | | 24b. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| March Funeral Home 1101 E. North Ave. | | DEC 23 1986 | | Julia Benson-Randall | |

MEDICAL CERTIFICATION

92

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use on the burial-transit permit. Then please remove this page. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

028121 DEC 29 1986

20% COTTON & 15% H

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH THE DEATH CERTIFICATE. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT PAGE AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

1. DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Edward

C.

Sonberg

20. DATE KNOWN
OF DEATH ESTI-
MATED ☒ MONTH DAY YEAR

12 15 19 86

21. HOUR
M

3. SEX

Male

4. RACE

White

5. DATE OF BIRTH
MONTH DAY YEAR
March 16, 1910

6. AGE (IN YEARS
LAST BIRTHDAY)
76 YRS.

IF UNDER 1 YR.
MONTHS DAYS HOURS MIN.

IF UNDER 24 HRS.
MONTHS DAYS HOURS MIN.

22. DATE
PRONOUNCED
DEAD

12 15 19 86

23. HOUR
P M

7a. BIRTHPLACE (STATE OR
FOREIGN COUNTRY)
Maryland

7b. CITIZEN OF WHAT COUNTRY?
U.S.A.

8. MARRIED ☒ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City,

MD.

10. CITY OR TOWN OF DEATH
Baltimore

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
2300 Hamilton Avenue

12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE)
Self-Employed

12b. KIND OF BUSINESS
OR INDUSTRY
Grocer

13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE
Maryland

13b. COUNTY

13c. CITY OR TOWN
Baltimore

13d. INSIDE CITY LIMITS?
YES ☒ NO ☐

13e. STREET ADDRESS
2300 Hamilton Ave. 21214

14. FATHER'S NAME
FIRST MIDDLE LAST

Charles

Sonberg

15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST

Anna

Pouska

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No

16b. SOCIAL SECURITY NO.
218-32-1930

17. INFORMANT
ADDRESS
Mrs. Rosalie E. Sonberg

Same as #13e

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Gunshot wound of head

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a) stating the under-
lying cause lost.

(b) _____
DUE TO, OR AS A CONSEQUENCE OF

(c) _____

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.

MEDICAL CERTIFICATION

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR
CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY
HOUR ~~2:00~~ MONTH DAY YEAR
12:04 M. 12 15 19 86

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

Subject shot

21d. INJURY OCCURRED
WHILE ☒ NOT WHILE ☐
AT WORK AT WORK

21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.)
store

21f. LOCATION
STREET CITY OR TOWN COUNTY STATE

2300 Hamilton Ave, Balto.

MD.

22a. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐.

ACTUAL
SIGNATURE

TITLE (SPECIFY)

M.D. Assistant MEDICAL EXAMINER

DATE SIGNED 12/16/86

EXAMINER'S NAME
(TYPE OR PRINT)

William M. Zane, M.D.

ADDRESS 111 Penn St. Balto.MD.

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)

Entombment

23b. DATE

12-19-86

23c. NAME OF CEMETERY OR CREMATORY

Lorraine Park

23d. LOCATION
CITY OR TOWN COUNTY STATE

Baltimore, Maryland

24. FUNERAL DIRECTOR
NAME

ADDRESS

Leonard J. Ruck, Inc.

Baltimore, Md.

25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

DEC 17 1986

Julia Davidson-Randall

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

057-1-130

6

John - [illegible]

John - [illegible]

John - [illegible]

John - [illegible]

057-1-130



John - [illegible]

John - [illegible]

057-1-130

John - [illegible]

029380 JAN 16 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|--|--|---|--|---|--|--|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
SOPHER MORRIS SOPHER | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12/28/86 | | | | 2b. HOUR
4:05 PM | |
| 3. SEX
MALE | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH
MONTH DAY YEAR
09/14/88 | | 6. AGE (IN YEARS LAST BIRTHDAY)
64 YRS | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | | | |
| 7a. BIRTHPLACE
(COUNTRY)
POLAND | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTO. CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE CITY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SINAI HOSPITAL OF BALTIMORE | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
SALESMAN | | 12b. KIND OF BUSINESS OR INDUSTRY
RETAIL | | | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
BALTO | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
26 WARREN PARK DRIVE 21208 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
ABRAHAM SOPHER | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
LESTER SILVERSTEIN | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WWII-ARMY 216-12-3909 | | 17. INFORMANT
MRS. ROSE GINSBERG | | APT. 2A
26 WARREN PARK DR. #21208 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) Cardiogenic shock
DUE TO, OR AS A CONSEQUENCE OF
(c) RESISTANT ARRYTHMIA | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
1 min
4 hours | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
Diabetes mellitus, peripheral vascular disease, malignant arrhythmia | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/28 , 19 86 , to 12/28 , 19 86 , that (I) (we) last
saw the deceased alive on 12/28 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. PHYSICIAN'S SIGNATURE
Arnon D. Goldberg | | | | | | DEGREE | | 22c. DATE SIGNED
12/28/86 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Arnon D. Goldberg | | | | | | 22e. ADDRESS
SINAI HOSPITAL OF BALTO | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | | | 23b. DATE
DEC. 30, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY
PETACH TIKVAH | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
ROSEDALE BALTO. MD | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
SOL LEVINSON & BROS., INC.
6010 REISTERSTOWN RD. BALTO., MD 21215 | | | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 6 1987 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | | |

BP.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this certificate from the body of the deceased and return it to the State Dept. of Health and Mental Hygiene prior to burial, cremation or other final disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|---|--|---|--|--|--|
| 1. FOR
STATE
REGISTRAR | | REG. NO. | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
ADDIE M. Southerns | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
12/26/86 | | 2b. HOUR
2:30P M | |
| 3. SEX
FEMALE | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
12 15 07 | | 6. AGE (IN YEARS LAST BIRTHDAY)
79 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
NORTH CAROLINA | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALT city, MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALT | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
BOR Secoun Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MD 13b. COUNTY BALT 13c. CITY OR TOWN | | | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
3313 Poplar St 21216 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
THOMAS SOUTHERNS | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
TERNETTER MCCLURE | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO.
213 180485 | | 17. INFORMANT
ADDRESS
Mrs Oressa Miles 1701 Eutaw Pk 21212 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral VASCULAR Accident
DUE TO, OR AS A CONSEQUENCE OF (b) ASCLO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) arrhythmia
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c) | | | | | | | | | |
| MEDICAL CERTIFICATION | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/23/86, 19, to 12/26, 19 86, that (I) (we) last saw the deceased alive on 12/26, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
MARIL DAVIS MD | | | | | | DEGREE
MD | | 22c. DATE SIGNED
12/28/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MARIL DAVIS MD | | | | | | 22e. ADDRESS
4051 BARTMAN AVE C.C. 212043 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
B | | 23b. DATE
12/31/86 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt Calvary C | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Joseph E. Russ 2222 W. York Ave | | | | | | 25a. DATE REC'D BY REG. (PAR 2) | | 25b. REGISTRAR'S SIGNATURE
Julia Decker-Randall | |

BP

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be completed and signed by the attending physician within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it is to be filed in the funeral director's office. It should be detached for use on the burial/transit permit. This permit is to be filed in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked on item 1B, allow any injury, or other traumatic event, the medical examiner must be involved at once.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | |
|---|--|---|---|---|--|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
MARY (MILDRED) MARIE SPINDLER | | | 2a. DATE OF DEATH MONTH DAY YEAR
DECEMBER 9, 1986 | | | 2b. HOUR
4:23 ^M | | | | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR
MARCH 31 1923 | | 6. AGE (IN YEARS LAST BIRTHDAY)
63 YRS | | 7. IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 72 HRS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
JOHNS HOPKINS HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK OR MOST OF WORKING LIFE)
HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY
----- | | |
| 13a. STATE
MARYLAND | | | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
CHARLES ITNYRE | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
ANNA FLORENCE GROSS | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO --- | | | | 16b. SOCIAL SECURITY NO
213-20-8024 | | 17. INFORMANT ADDRESS
glen burnie, MD 21067
ROBERT SPINDLER 802 BARBARA COURT | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) <u>RESPIRATORY ARREST</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>PULMONARY EDEMA</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>AORTIC VALVE INSUFFICIENCY</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:
<u>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 MIN | | |
| | | | | | | | | 10 DAYS | | |
| | | | | | | | | 12 DAYS | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
1. WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>NOVEMBER 14, 1986</u> to <u>DECEMBER 9, 1986</u> , that (I) (we) last saw the deceased alive on <u>DECEMBER 9, 1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Elvin Barr MD | | | | | | DEGREE | | 22c. DATE SIGNED
12/9/86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ELVIN BARR MD | | | | | | 22e. ADDRESS
JOHNS HOPKINS HOSP
600 N. WOLFE ST BALT MD 21205 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | | 23b. DATE
DEC 12 1986 | | 23c. NAME OF CEMETERY OR CREMATORY
OAK LAWN CEMETERY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE MD | | | |
| 24. FUNERAL DIRECTOR
NAME LILLY & ZEILER, INC. 1901 ADDRESS EASTERN AVE. 21231 | | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 11 1986 | | 25b. REGISTRAR'S SIGNATURE
John Davidson-Randall | | |

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | |
|---|--|--|--|--|--|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Edna. WILLIAMS Spady | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 28 86 | | | 2b. HOUR
1835 M. | | | | |
| 3. SEX
FEMALE | | 4. RACE
BLACK | | 5. DATE OF BIRTH
MONTH DAY YEAR
6 13 15 | | 6. AGE (IN YEARS LAST BIRTHDAY)
71 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
CITY. MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Sinai Hospital of Baltimore. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
SECRETARY | | 12b. METROPOLITAN UNITED METHODIST CHURCH | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
M.D. | | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
1701 APT 1016 BALTO. MD. EUTAW PL. 21217 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
EARL BROOKS | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MABLE L. GREEN | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | | | |
| 16b. SOCIAL SECURITY NO.
216-20-1331 | | | 17. INFORMANT MRS. BALTIMORE, MD. 21217 | | | 17b. RAMONA A. ROBERTS 1701 EUTAW PL. APT 1016 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Upper GI bleed.
DUE TO, OR AS A CONSEQUENCE OF
(b) Hepatic encephalopathy
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from Dec 12 , 19 86 , to Dec 28 , 19 86 , that (I) (we) lost saw the deceased alive on Dec 28 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Youngmee Kim | | | DEGREE | | | 22c. DATE SIGNED
12/28/86 | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Youngmee Kim | | | 22e. ADDRESS
c/o Sinai Hospital of Baltimore | | | | | | | |
| 23a. DECEASED CREMATION, REMOVAL (SPECIFY)
ENTOMBMENT | | | 23b. DATE
1/02/1987 | | 23c. NAME OF CEMETERY OR CREMATORY
CEDAR HILL CEM. | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE, MARYLAND | | |
| 24. FUNERAL HOME OR OTHER PERSON TO WHOM BODY WAS DELIVERED
NAME ADDRESS
NEPTER + SONS FUNERAL HOME, INC. 2501 Gwynns Falls Pkwy. BALTO. MD. 21216 | | | | | | 25. DATE REC'D. BY REGISTRAR
DEC 31 1986 | | 25. REGISTRAR'S SIGNATURE
Julia Anderson-Randee | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please have carbon copies. Pages 1 and 2 should be filed with the health department within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

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07- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | |
|---|--|---|--|---|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) <i>Charles IRVING Spangler</i> | | | 2a. DATE OF DEATH MONTH DAY YEAR
<i>12 31 86</i> | | | 2b. HOUR <i>10 AM</i> | | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
Sept. 13, 1890 | | 6. AGE (IN YEARS LAST BIRTHDAY)
.96 yrs. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Balto</i> MD. | | | | |
| 10. CITY OR TOWN OF DEATH
<i>Balto</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
<i>Mason F. Lord (FSKMC)</i> | | | | 12a. USUAL OCCUPATION
Playground Dir. | | 12b. KIND OF BUSINESS OR INDUSTRY
City of Balto. | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
STATE
Maryland | | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
533 Oakland Ave. 21212 | |
| 14. FATHER'S NAME
FIRST UNKNOWN LAST | | | | 15. MOTHER'S MAIDEN NAME
FIRST UNKNOWN LAST | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO.
214.40.5731 | | 17. INFORMANT
Ardena Reddish (FSKMC--Eastern Ave. Baltimore, Md. 21224) | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) <i>Aspiration Pneumonia</i>
DUE TO, OR AS A CONSEQUENCE OF
(b) <i>NIDDM</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i>Dementia</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (this hospital) attended the deceased from <i>8/6/10</i> 19 <i>74</i> to <i>12/31</i> 19 <i>86</i> , that (we) last saw the deceased alive on <i>12/31</i> 19 <i>86</i> , and that in (we) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<i>John Hoh, M.D.</i> | | | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
<i>12/31/86</i> | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>John Hoh, M.D.</i> | | | | | 22e. ADDRESS
<i>5200 Eastern Ave. Baltimore, MD 21224</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
1/5/1987 | | 23c. NAME OF CEMETERY OR CREMATORY
Oak Lawn Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Maryland | | | |
| 24. FUNERAL DIRECTOR
Walter Brooks Bradley Inc., Dundalk, Md. 21222 | | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 5 1987 | | | | | |
| | | | | | 25b. REGISTRAR'S SIGNATURE
<i>Julia Anderson-Rendall</i> | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please place all the papers, Page 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

BP

10-11-1965

203 WILLOW LANE
CHICAGO, ILL. 60614



10-11-1965
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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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FOR
1- STATE
REGISTRAR

REG. NO.

| | | | | | | | |
|--|--|---|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) JACQUELINE SPANN | | | 2a. DATE OF DEATH MONTH DAY YEAR
12/31/86 | | | 2b. HOUR
1:15 P.M. | |
| 3. SEX
FEMALE | | 4. RACE
BLACK | | 5. DATE OF BIRTH
MONTH DAY YEAR
7/03/52 | | 6. AGE (IN YEARS LAST BIRTHDAY)
34 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
BON SECOURS HOSP. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
UNEMPLOYED. | | 12b. KIND OF BUSINESS OR INDUSTRY
- | |
| 13a. STATE
MD. | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
EUGENE SPANN | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
GERALDINE WHITING | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
218-56-1989 | |
| 17. INFORMANT
ADDRESS
1229 GLENWOOD AVE. BALTO. MD. 21239 | | | | | | | |

| | | | |
|--|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) acute cerebrovascular accident | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| DUE TO, OR AS A CONSEQUENCE OF
(b) intracerebral bleeding | | | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) thrombotic heart disease | | | |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **0**

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
IN HOME <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/17 , 19 86 , to 12/31 , 19 86 , that (I) (we) lost
saw the deceased alive on 12/31 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Bernardo D. P. 2AW | | | | DEGREE
MD | | 22c. DATE SIGNED
12/31/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
BERNARDO D. P. 2AW | | | | 22e. ADDRESS
2000 W. BALTIMORE ST. 21223 | | | |

| | | | | | | | |
|---|--|-------------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) BURIAL | | 23b. DATE
1/08/1987 | | 23c. NAME OF CEMETERY OR CREMATORY
CEDAR HILL CEMETERY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Maryland | |
| 24. NAME OF FUNERAL HOME, INC.
2501 Gwynns Falls Pkwy. Baltimore, Md. 21216 | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 6 1987 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return pages 1, 2 and 3 to the State Dept. of Health and Mental Hygiene prior to burial, cremation or other disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

BP

[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "The", "and", "of" are visible.]



DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | | | | | | | |
|--|--|---|--|---|--|--|--|--|--|---|--|
| FOR
STATE
REGISTRAR | | | | STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | | | |
| 1. DECEASED NAME
(TYPE OR PRINT)
NELLIE SPRAGG | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
DECEMBER 6, 1986 | | | | 2b. HOUR
1:30 am | | | |
| 3. SEX
Caucasian Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
12 25 1919 | | 6. AGE (IN YEARS LAST BIRTHDAY)
66 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Italy | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Church Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
retired-cashier | | | 12b. KIND OF BUSINESS OR INDUSTRY
Haussner's Rest. | | |
| 13a. STATE
Md. | | 13b. COUNTY
Balto. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
3400 E. Pratt Street 21224 | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Emilio Manzo | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Frances Raymond | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
235-40-0593 | | 17. INFORMANT ADDRESS
Mr. Marblich Spragg, 3400 E. Pratt St. 21224 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CEREBRAL VASCULAR ACCIDENT
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) HYPERTENSION
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4 DAYS | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)
TYPE II DIABETES MELLITUS | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (1) this hospital attended the deceased from DECEMBER 1, 1986 , to DECEMBER 6, 1986 , that (1) we last saw the deceased alive on DECEMBER 6, 1986 , and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above, (1) we did (did not) see the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<i>[Signature]</i> | | | | DEGREE | | | | 22c. DATE SIGNED
12/6/86 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Jonathan D. Kushner | | | | 22e. ADDRESS
CHURCH HOSPITAL CORPORATION
101 N. BROADWAY, BALTIMORE, MD. 21231 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
12/9/86 | | 23c. NAME OF CEMETERY OR CREMATORY
Sacred Heart of Jesus | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Maryland | | | |
| 24. FUNERAL DIRECTOR
Joseph N. Zannino | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 9 1986 | | | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | |



026330 DEC - 1986

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | |
|--|--|--|---|---|---|--|
| 1 DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
SAMUEL (I.) STANFIELD | | | 2a DATE OF DEATH
MONTH DAY YEAR
DECEMBER 3, 1986 | | 2b HOUR
A M
8:05 | |
| 3 SEX
MALE | | 4 RACE
BLACK | | 5 DATE OF BIRTH
MONTH DAY YEAR
1 - 22 - 16 | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | | 7b CITIZEN OF WHAT COUNTRY?
USA | | 6 AGE (IN YEARS LAST BIRTHDAY)
70 YRS.
IF UNDER 1 YEAR: MONTHS DAYS
IF UNDER 72 HRS: HOURS MIN. | | |
| 10 CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
JOHNS HOPKINS HOSPITAL | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | |
| 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
LONGSHOREMAN | | | 12b KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
MD | | | 13b. COUNTY
BALTO. | | 13c. CITY OR TOWN
BALTO. | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
SAMUEL STANFIELD | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE
CARRIE YANCY | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | | 16b SOCIAL SECURITY NO.
245076111 | | 17. INFORMANT
ADDRESS
CHRISTINE PULLEN 2029 N. WOLFE ST. | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio pulmonary Arrest
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) Multiple Myeloma
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
10 minutes
1 year | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | |
| 21d INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a I certify that (I) (this hospital) attended the deceased from November 30 , 19 86 , to December 3 , 19 86 , that (I) (we) last saw the deceased alive on December 3 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b SIGNATURE
Steven Geller MD | | DEGREE | | 22c DATE SIGNED
12/3/86 | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)
STEVEN Geller M.D. | | 22e ADDRESS
Johns Hopkins Hospital 600 N. Wolfe St Balto. MD 21205 | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b DATE
12 6 86 | | 23c NAME OF CEMETERY OR CREMATORY
ARBUTUS CEM. | | |
| 24 FUNERAL DIRECTOR
NAME ADDRESS
MARCH FUNERAL HOME 1101 E. NORTH AVE. | | 23d LOCATION
CITY OR TOWN COUNTY STATE
ARBUTUS MD | | 25a DATE REC'D. BY REGISTRAR
DEC 5 1986 | | |
| | | | | 25b REGISTRAR'S SIGNATURE
Davidson-Randall | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The 01 (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) (11) (12) (13) (14) (15) (16) (17) (18) (19) (20) (21) (22) (23) (24) (25) (26) (27) (28) (29) (30) (31) (32) (33) (34) (35) (36) (37) (38) (39) (40) (41) (42) (43) (44) (45) (46) (47) (48) (49) (50) (51) (52) (53) (54) (55) (56) (57) (58) (59) (60) (61) (62) (63) (64) (65) (66) (67) (68) (69) (70) (71) (72) (73) (74) (75) (76) (77) (78) (79) (80) (81) (82) (83) (84) (85) (86) (87) (88) (89) (90) (91) (92) (93) (94) (95) (96) (97) (98) (99) (100) (101) (102) (103) (104) (105) (106) (107) (108) (109) (110) (111) (112) (113) (114) (115) (116) (117) (118) (119) (120) (121) (122) (123) (124) (125) (126) (127) (128) (129) (130) (131) (132) (133) (134) (135) (136) (137) (138) (139) (140) (141) (142) (143) (144) (145) (146) (147) (148) (149) (150) (151) (152) (153) (154) (155) (156) (157) (158) (159) (160) (161) (162) (163) (164) (165) (166) (167) (168) (169) (170) (171) (172) (173) (174) (175) (176) (177) 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**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO.

1- FOR
STATE
REGISTRAR

DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Ralph

G.

Stanley

2a. DATE KNOWN OF DEATH ☐ MONTH ☐ DAY ☐ YEAR ☒ 12 16 19 86 2b. HOUR M

3. SEX
male

4. RACE
black

5. DATE OF BIRTH
MONTH DAY YEAR
12 22 1953

6. AGE (IN YEARS)
LAST BIRTHDAY
32 YRS.

IF UNDER 1 YR.
MONTHS DAYS

IF UNDER 24 HRS.
HOURS MIN.

7c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
12 16 19 86

2d. HOUR
2:20A M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md

7b. CITIZEN OF WHAT COUNTRY?
U S A

8. MARRIED ☐ NEVER MARRIED ☒
WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD

10. CITY OR TOWN OF DEATH
Baltimore

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
5619 Frankford Avenue

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Unemployed

12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md

13b. COUNTY

13c. CITY OR TOWN
Baltimore

13d. INSIDE CITY LIMITS?
YES ☒ NO ☐

13e. STREET ADDRESS
5619 Frankford Avenue 21206

14. FATHER'S NAME
FIRST MIDDLE LAST
Prince Stanley

15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mildred Evans

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.
N/A

17. INFORMANT ADDRESS
Prince Stanley 758 Linnard Street

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Narcotic intoxication

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

(b) _____
DUE TO, OR AS A CONSEQUENCE OF

(c) _____

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?
YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR
CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
? P.M. 12 16 19 86

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
subject used drugs

21d. INJURY OCCURRED
WHILE ☐ NOT WHILE ☒
AT WORK AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
home

21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
5619 Frankford Ave, Balto. MD.

22a. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☒

ACTUAL SIGNATURE William M. Zane M.D. Assistant MEDICAL EXAMINER DATE SIGNED 12/16/86

EXAMINER'S NAME (TYPE OR PRINT) William M. Zane, M.D. ADDRESS 111 Penn St. Balto. MD.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial

23b. DATE
12/20/86

23c. NAME OF CEMETERY OR CREMATORY
Eastview Cemetery

23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore MD

24. FUNERAL DIRECTOR
NAME ADDRESS
March Funeral Home West 4300 Wabash Avenue

25a. DATE REC'D. BY REGISTRAR
DEC 23 1986

25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall

028120

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAYS ARE NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP
DHMH - 17
(VR A15 ME (5))

05112-10-12



05112-10-12

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|--|--|--|--|---|---|--|
| 1- FOR STATE REGISTRAR
Rose Stansbury | | | | | REG. NO. | | | | |
| 1 DECEASED NAME (TYPE OR PRINT)
Rose Stansbury | | | | | 2a DATE OF DEATH MONTH DAY YEAR
12 26 86 | | | | |
| 3 SEX
Female | | 4 RACE
White | | 5 DATE OF BIRTH
Jan. 29, 1905 | | 6 AGE (IN YEARS LAST BIRTHDAY)
81 YRS | | 7b HOUR
1: M | |
| 7a BIRTHPLACE (STATE OR FOREIGN)
Baltimore, Md. | | 7b CITIZEN OF WHAT COUNTRY?
USA | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10 CITY OR TOWN OF DEATH
Baltimore | | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Frances Scott Key Hospital | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Seamstress | | 12b KIND OF BUSINESS OR INDUSTRY
Clothing Mfg. | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE Maryland 13b. CITY Baltimore 13c. CITY OR TOWN Essex | | | | | 13d INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e STREET ADDRESS / ZIP CODE
700 Virginia Ave. 21221 | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST
John J. Dombrowski | | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Frances | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | 16b SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
- | | 17 INFORMANT
Joseph W. Stansbury Son | | ADDRESS 136 Breakwater Ct. Joppa, Md. 21085 | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Gm negative Sepsis</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Klebsiella + Pseudomonas Pneumonia</u> | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 Days |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from 12/19/86 to 12/26/86, that (I) (we) last saw the deceased alive on 12/26/86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b SIGNATURE
R. Healy | | | | DEGREE | | 22c DATE SIGNED
12/26/86 | | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)
Healy | | | | 22e ADDRESS
Frances Scott Key MC. 4940 Eastern Ave Balt | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b DATE
12/29/86 | | 23c NAME OF CEMETERY OR CREMATORY
Lakewood Memorial Park | | 23d LOCATION
CITY OR TOWN COUNTY STATE
Sykesville, Md. | | | |
| 24 FUNERAL DIRECTOR
Brudzinski Funeral Home PA 1407 Old Eastern Ave | | | | | | 25a DATE REC'D. BY REGISTRAR
DEC 30 1986 | | 25b REGISTRAR'S SIGNATURE
A. J. ... | |

100-100000-100000

100-100000-100000

Nov. 14, 1914

x

1914

Washington, D.C.

Glenn H. Smith

Secretary

700 Virginia Ave. S.W.

Washington, D.C.

James

John W. Thompson

110 Pennsylvania St.

200 07 0000 - Joseph W. Thompson for James, No. 1100

No

11/1/14 Interview with James W. Thompson, No.

11/1/14

James

Washington, D.C. 1100 07 0000 - James W. Thompson, No. 1100

028065 DEC 1986

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | |
|---|---------|------------------|--|----------------|------------------|--|----------------|--|---|----------|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2b. DATE KNOWN OF DEATH | | | MONTH DAY YEAR | | | 2d. HOUR | | |
| CHARLES L. STAPF | | | | | | 12-18-86 | | | 19 | | | M | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) | IF UNDER 1 YR. | IF UNDER 24 HRS. | 7c. DATE PRONOUNCED DEAD | MONTH DAY YEAR | | | 2d. HOUR | | | | |
| Male | White | 3 28 24 | 62 YRS | | | 12-18-86 | 19 | | | 5:25 PM | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | MD. | | |
| MD | | | USA | | | | | | Baltimore City | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Baltimore | | | St. Agnes Hospital | | | Clearance Chief Rail Road | | | | | | | | |
| 13a. STATE | | | 13b. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? | | | 13e. STREET ADDRESS | | | | | |
| MD | | | Baltimore | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 1117 McAdoo Avenue | | | 21207 | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT ADDRESS | | |
| August Stapf | | | Clara Smelzer | | | Yes | | | 216-16-3076 | | | Mary Grace Stapf same as #13e | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a). <u>Arteriosclerotic cardiovascular disease</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? | | | | | |
| | | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | TITLE (SPECIFY) | | | | | | DATE SIGNED | | | | | |
| Margarita A. Korell | | | M.D. Assistant | | | | | | 12-19-86 | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | ADDRESS | | | | | | | | | | | |
| Margarita A. Korell, M.D. | | | 111 Penn Street | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | | | |
| Burial | | | 12-22-86 | | | Loudon Park Cemerty | | | Baltimore, City MD | | | | | |
| 24. FUNERAL DIRECTOR NAME | | | ADDRESS | | | 25a. DATE REC'D BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| MacNabb Funeral Home | | | 301 Frederick Rd. Catonsville, MD | | | DEC 21 1986 | | | John Anderson-Randall | | | | | |

DIVISION OF VITAL RECORDS, 201 W. BOSTON ST., BALTIMORE, MD, 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM TM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. BOSTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07-84
25M

BP

DHMH - 17
(VR A15 ME (5))

029358 JAN

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|------------------------------------|---|--|--------|------|--|-----------------|-----------------------------------|-----------------|----------|
| 1 DECEASED NAME
(TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | MONTH | DAY | YEAR | 2b. HOUR |
| Elizabeth Staton | | | | | Dec. 31, 1986 | | | | 1:15 AM |
| 3 SEX | 4 RACE | 5. DATE OF BIRTH | | | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR | | IF UNDER 24 HRS | |
| Female | Black | 07 06 92 | | | 94 | MONTHS | | DAYS | |
| 7a. BIRTHPLACE
COUNTY | 7b. CITIZEN OF WHAT COUNTRY? | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | | |
| North Carolina | U.S.A. | | | | Baltimore City MD. | | | | |
| 10 CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Baltimore | Mason F Lord Chronic Hospital | | | | retired | | | | |

| | | | | | | |
|---|--|--------------------------|-------------|----------------------------------|---|--------------------------------|
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE |
| MD. | | | | Baltimore | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 1422 E. Preston St 21213 |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | | | |
| Neal - Hayes | | Sally - Jacobs | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | |
| NO | | 210-22-7825A | | Sally Parker 1424 E. Federal St. | | |

| | | |
|---|--|---|
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: | | |
| IMMEDIATE CAUSE (a) Cardiopulmonary Arrest | | 10 |
| DUE TO, OR AS A CONSEQUENCE OF | | |
| (b) Aspiration | | |
| DUE TO, OR AS A CONSEQUENCE OF | | |
| (c) Cerebral Vascular Accident (Stroke) | | |

| | | | |
|--|--|--|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | |
| History of embolic events including to legs | | | |

| | | | |
|--|--|--|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH? |
| | | YES <input type="checkbox"/> NO <input type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| | | | |

| | |
|---|--|
| 22a. I certify that (I) (this hospital) attended the deceased from March 4, 19 86, to Dec 31, 19 86, that (I) (we) last saw the deceased alive on Dec 31, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | |
|---|--|

| | | |
|---------------------------------------|--|------------------|
| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
| John Hoh, MD. | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 12/31/86 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS | |
| John Hoh, MD. | 5200 Eastern Ave Baltimore, MD | |

| | | | |
|--|-----------|------------------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL
SPECIFY | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION
CITY OR TOWN COUNTY STATE |
| Burial | 1-5-87 | Mt. Calvary | Ann Arundel County, MD |

| | | |
|------------------------------|-------------------------------|----------------------------|
| 24. FUNERAL DIRECTOR
NAME | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
| Calvin B. Scruggs - | JAN 5 1987 | Julia Anderson-Rudner |

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

BP

CONFIDENTIAL

029352 JAN - 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 3 4 9 9 5

REG. NO.

| | | | | | | | | | | | |
|---|--|---|--|---|---|--|---|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Christopher M. Steadman | | | 2a. DATE OF DEATH
MONTH DAY YEAR
Dec 31 86 | | | 2b. HOUR
5 18 PM | | | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
3 18 01 | | 6. AGE (IN YEARS LAST BIRTHDAY)
85 YRS. | | | | | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
Ireland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Good Samaritan Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Construction | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
Md. | | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
1707 Sherwood Avenue 21239 | | |
| 14. FATHER'S NAME
MIDDLE Steadman LAST | | | | 15. MOTHER'S MAIDEN NAME
MIDDLE MacDonald LAST | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES NO OR UNKNOWN)
no | | | 16b. SOCIAL SECURITY NO.
212-30-2147 | | 17. INFORMANT
Mrs. Eileen C. Steadman | | | ADDRESS
Same | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarction
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 days | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)
DM. HTN | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/29 19 86 to 12/31 19 86 that (I) (we) lost
saw the deceased alive on 12/31 19 86 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Victor Chang MD | | | DEGREE
MD | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED
12/31/86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
VICTOR CHANG | | | 22e. ADDRESS
GOOD SAMARITAN Hospital | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
Jan. 5, 1987 | | 23c. NAME OF CEMETERY OR CREMATORY
Meadowridge Mem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Dorsey Md. | | | | |
| 24. FUNERAL DIRECTOR
NAME
Leonard J. Ruck Inc. Baltimore, Maryland | | | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 5 1987 | | 25b. REGISTRAR'S SIGNATURE
Julia Jensen-Rudner | | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in accordance with the instructions of the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and checked.

BP _____

DHMH - 16 60M 7/84
(VRA 15, 4)

02-23-60

Jan 21 86 12 p

24-25-60

Christy

M. W.

Constitution

Constitution

Constitution

17-30-60 (Jan 21 86)

x

Constitution

Constitution

Constitution

Constitution

Constitution

Constitution

Constitution (17-30-60)

2 days

Constitution

Jan 21 86

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Constitution

Jan 21 86

Constitution

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Constitution

Constitution

Constitution

029339 JAN-87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon copy (page 3) and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | | |
|--|--|--|--|--|---|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) ADDIE Sterling C. STERLING | | | | | 2a. DATE OF DEATH MONTH DAY YEAR December 29, 1986 | | | | | 2b. HOUR 11:30 P.M. | |
| 3. SEX Female | | 4. RACE Cauc. | | 5. DATE OF BIRTH MONTH DAY YEAR March 4, 1901 | | 6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore City | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 36 E. 26th St. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY At home | | | |
| 13a. STATE MD 13b. COUNTY Somerset | | | | 13c. CITY OR TOWN Crisfield | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 73 Richardson Ave. / 21817 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Christopher C. Tyler | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillie M. Tyler | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. 216-14-2551 | | 17. INFORMANT ADDRESS 36 E. 26th St. Olin R. Bedsworth, Jr. - Baltimore, MD 21218 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of ovary
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 months | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> hospice | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that Dr. (this hospital) attended the deceased from Dec 5 19 86 , to Dec 29 19 86 , that (we) last saw the deceased alive on Dec 29 19 86 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) not view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE W.B. Daniels, Jr. M.D. | | | | DEGREE | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 12/30/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) W.B. Daniels, Jr. | | | | 22e. ADDRESS Union Memorial Hospice Balto 21218 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SEE P. 1) Burial | | | | 23b. DATE Jan. 3, 1987 | | 23c. NAME OF CEMETERY OR CREMATORY Crisfield Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Crisfield - Somerset - MD | | | |
| 24. FUNERAL DIRECTOR Bradshaw & Sons Funeral Home - MD 21817 | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE John A. ... | | | |

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RECEIVED
FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE
WASHINGTON, D. C.

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FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE
WASHINGTON, D. C.

RECEIVED
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U. S. DEPARTMENT OF JUSTICE
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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | |
|---|-------------------------|--|--|---|---|--|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
OLIVER SYLVESTER STERN | | | 2a. DATE KNOWN OF DEATH
<input checked="" type="checkbox"/> MONTH DAY YEAR
12-18-86 | | | 2b. HOUR
M | | |
| 3. SEX
Male | 4. RACE
Black | 5. DATE OF BIRTH
MONTH DAY YEAR
Oct. 13, 1930 | 6. AGE (IN YEARS LAST BIRTHDAY)
56 YRS. | IF UNDER 1 YR.
MONTHS DAYS
19 | IF UNDER 24 HRS.
HOURS MIN.
11:52 | 7c. DATE PRONOUNCED DEAD
12-18-86 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Union Memorial Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Recreation Ctr. Dir. | | 12b. KIND OF BUSINESS OR INDUSTRY
Bur. Rec. |
| 13a. STATE
Maryland | | | 13b. COUNTY
Baltimore | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
2109 Ellamont Street 21216 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Oliver Sylvester Stern, Sr. | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Carrie Carr | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO.
220-24-1725 | | 17. INFORMANT ADDRESS
Dorothy Wood Stern 2109 Ellamont Street 21216 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | |
| ACTUAL SIGNATURE
<i>Margarita A. Korell</i> | | | | TITLE (SPECIFY)
M.D. Assistant | | | DATE SIGNED
12-19-86 | |
| EXAMINER'S NAME (TYPE OR PRINT)
Margarita A. Korell, M.D. | | ADDRESS
111 Penn Street | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
12-22-86 | | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore City Md. | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Marshall W. Jones, Jr. FH 4101 Edmondson Ave. 21229 | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 22 1986 | | 25b. REGISTRAR'S SIGNATURE
<i>Julia Anniston Rucker</i> | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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cc. 12, 13, 14

Information Cer. Dir. R. Rec.

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FOR
1 - STATE
REGISTRARDEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

5 6

REG. NO.

34998-

| | | | | | | | | | | | | |
|---|--|---|--|---|--|---|--|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
ANN A | | FIRST
Louise | | MIDDLE
STEVEN S | | LAST | | 20. DATE OF DEATH
MONTH DAY YEAR
12 20 86 | | 2b. HOUR
7:24 PM | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
5 18 10 | | 6. AGE (IN YEARS LAST BIRTHDAY)
76 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Mercy Hospital, Balto. Md. | | | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
Maryland | | 13b. COUNTY
----- | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
1206 Battery Ave, Balto. Md. 21230 | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Robert ----- Downey | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ida ----- Billingham | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | | |
| 16b. SOCIAL SECURITY NO.
220-22-4631 | | | | 17. INFORMANT
ADDRESS
Balto. Md. 21230
Mrs. Esther M. Dawalt, 1200 Riverside Ave | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Ventricular Fibrillation</u> | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
1 hour. | | |
| DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>myocardial Infarction - Possible</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Coronary Artery Disease</u> | | | | | | | | | | 1 hour. | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/20</u> 19 <u>86</u> , to <u>12/20</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>12/20</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Robert C. Greenwell MD</u> | | | | DEGREE
<u>MD</u> | | | | 22c. DATE SIGNED
<u>12-20-86</u> | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>Robert C. Greenwell MD</u> | | | | 22e. ADDRESS
<u>301 St. Paul Pl. (Mercy Hospital)</u> | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
12/23/86 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemt. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto. A.A.Co. Md. | | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Balto. Md. 21230
McCully Funeral Home, 130 E. Fort Ave. | | | | | | 25a. DATE REC'D BY REGISTRAR
DEC 23 1986 | | 25b. REGISTRAR'S SIGNATURE
<u>Julia Anderson-Randall</u> | | | | |

MEDICAL CERTIFICATION

235

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove, or detach, pages 1 and 2. These should be filed with the State Department of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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Item 16b, Film G622 12/15/86 job
 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|--|--|---|---|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
CHRISTIANNA STEWART | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 2 86 | | | 2b. HOUR
8 PM | | | |
| 3. SEX
Female | | 4. RACE
BLACK | | 5. DATE OF BIRTH
MONTH DAY YEAR
8 17 16 | | 6. AGE (IN YEARS LAST BIRTHDAY)
70 YRS | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 72 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
MERCY HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOMEMAKER | | 12b. KIND OF BUSINESS OR INDUSTRY
HOME | |
| 13a. STATE
MARYLAND | | | | 13b. COUNTY | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John Smallwood | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Cora Thomas | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No. | | | | 16b. SOCIAL SECURITY NO.
218-10-5771 | | 17. Shelton Stewart & Baltimore, Maryland
Dolores S. Lansey 6117 Talles Road, 21207 | | | |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Prolonged Hypotension
DUE TO, OR AS A CONSEQUENCE OF
(b) Myocardial Infarction.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(c) Atherosclerotic Coronary Artery Disease.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
12 hours.
26 hours. | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/2, 19 86 to 12/2, 19 86 that (I) (we) last saw the deceased alive on 12/2, 19 86 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Robert C. Greenwell Jr. MD | | | | | DEGREE
MD | | | 22c. DATE SIGNED
12-2-86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ROBERT C. Greenwell Jr. MD | | | | | 22e. ADDRESS
301 St. Paul Place - Baltimore MD | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | | 23b. DATE
12/06/1986 | | 23c. NAME OF CEMETERY OR CREMATORY
Arbutus Memorial Park | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Maryland | | |
| 24. FUNERAL HOME OR OTHER PERSON TO WHOM BODY WAS DELIVERED
NAME ADDRESS
NOTTER & SONS FUNERAL HOME, INC.
2501 GWYNNS FALLS PKWY. BALTIMORE, MD. 21216 | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 8 1986 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | |

MEDICAL CERTIFICATION

M

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or either of the medical examiner must be notified at once.

| No. | Name | Address | City | State |
|-----|----------------|-----------|-----------|-------|
| 1 | John | 2211 Wood | Baltimore | Md. |
| 2 | Thomas | 2211 Wood | Baltimore | Md. |
| 3 | Shelton Howard | 2211 Wood | Baltimore | Md. |
| 4 | John | 2211 Wood | Baltimore | Md. |
| 5 | John | 2211 Wood | Baltimore | Md. |
| 6 | John | 2211 Wood | Baltimore | Md. |
| 7 | John | 2211 Wood | Baltimore | Md. |
| 8 | John | 2211 Wood | Baltimore | Md. |
| 9 | John | 2211 Wood | Baltimore | Md. |
| 10 | John | 2211 Wood | Baltimore | Md. |

U.S. GOVERNMENT PRINTING OFFICE
1964 O - 301-001
Baltimore, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH: 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|---|--|--|--|---|
| 1 DECEASED NAME
(TYPE OR PRINT) <u>James Lee Stewart</u> | | | 2a DATE OF DEATH
MONTH <u>12</u> DAY <u>25</u> YEAR <u>86</u> | | 2b HOUR
<u>4 35</u> M |
| 3 SEX
<u>Male</u> | 4 RACE
<u>Black</u> | 5 DATE OF BIRTH
MONTH <u>5</u> DAY <u>4</u> YEAR <u>06</u> | 6 AGE (IN YEARS LAST BIRTHDAY)
<u>80</u> YRS. | | IF UNDER 1 YEAR
MONTHS <u> </u> DAYS <u> </u> |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<u>Mobile Ala.</u> | 7b CITIZEN OF WHAT COUNTRY?
<u>USA</u> | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH
<u>Baltimore City</u> MD. | | |
| 10 CITY OR TOWN OF DEATH
<u>Baltimore</u> | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<u>2611 Springhill Ave. Balto Md.</u> | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<u>Replacement Parts</u> | | 12b KIND OF BUSINESS OR INDUSTRY
<u>-</u> |
| 13a STATE
<u>Maryland</u> | | | 13b COUNTY
<u>-</u> | 13c CITY OR TOWN
<u>Baltimore</u> | |
| 14 FATHER'S NAME
FIRST <u>JIMMY</u> MIDDLE <u> </u> LAST <u>STEWART</u> | | | 15 MOTHER'S MAIDEN NAME
FIRST <u>ANNA</u> MIDDLE <u>LEE</u> LAST <u>WILSON</u> | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) <u>NO</u> | | 16b SOCIAL SECURITY NO.
<u>169-18-3445</u> | 17 INFORMANT
ADDRESS <u>Ernest Stewart 2611 Springhill Ave.</u> | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardio-pulmonary arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Aspiration pneumonia</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>CVA</u> | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | |
| 19a DATE OF OPERATION
<u>12/16</u> | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED
<u> </u> | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<u> </u> P.M. <u> </u> <u>19</u> | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION
STREET <u> </u> CITY OR TOWN <u> </u> COUNTY <u> </u> STATE <u> </u> | |
| 22a I certify that (I) (this hospital) attended the deceased from <u>12/16</u> 19 <u>86</u> to <u>12/25</u> 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>12/25</u> 19 <u>86</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b SIGNATURE
<u>T. I. Ohiorokrenhai, MD</u> | | DEGREE
<u>MD</u> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c DATE SIGNED
<u>12/25/86</u> | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)
<u>T. I. Ohiorokrenhai, MD</u> | | 22e ADDRESS
<u>Libert medical center</u> | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)
<u>Burial</u> | | 23b DATE
<u>12/31/86</u> | 23c NAME OF CEMETERY OR CREMATORY
<u>King Mem Park</u> | | 23d LOCATION
CITY OR TOWN <u>Randlestown Md.</u> COUNTY <u> </u> STATE <u> </u> |
| 24 FUNERAL DIRECTOR
NAME <u>March Funeral</u> ADDRESS <u>4300 Wabash Ave.</u> | | | 25a DATE REC'D. BY REGISTRAR <u>DEC 30 1986</u> 25b REGISTRAR'S SIGNATURE <u>Asia Davidson-Randall</u> | | |

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105-19 520350

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | REG. NO. | |
|---|--|--|---|---|---------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Julia M Stewart | | | 2a. DATE OF DEATH
MONTH DAY YEAR
Dec 28 1986 | | 2b. HOUR
6 A.M. | |
| 3. SEX
Female | | 4. RACE
B | | 5. DATE OF BIRTH
MONTH DAY YEAR
9 16 34 | | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
Baltimore, MD | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 6. AGE (IN YEARS LAST BIRTHDAY)
92 YRS
IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Bon Secours Hospital | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Home MGR. | | 12b. KIND OF BUSINESS OR INDUSTRY
at home | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Harry Carter | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
BERTIE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO.
216-10-0170 | | 17. INFORMANT
ADDRESS
Minor in Williams 1912 N. Bonnal... | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ASCVD
DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD
DUE TO, OR AS A CONSEQUENCE OF (c) PNEUMONIA
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 17 | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: DEHYDRATION | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, EARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (If this hospital attended the deceased from 12/28 1986 to 12/28 1986 , that (I) (we) saw the deceased alive on 12/28 1986 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (We) did not view the body after death. | | | | | | |
| 22b. SIGNATURE
Howard B. Cohen DEGREE MD | | | | 22c. DATE SIGNED
12/28/86 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
HOWARD B. COHEN, M.D. | | | | 22e. ADDRESS
5404 REISTERSTOWN RD. 21215 | | |
| 23a. BURIAL, CREMATION, REMOVAL
(TYPE OF)
Burial | | 23b. DATE
1/2/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt Calvary | | |
| 23d. LOCATION
(CITY OR TOWN) COUNTY STATE
Baltimore MD 21225 | | 24. FUNERAL DIRECTOR
NAME W. Hayes ADDRESS 638 29th St | | 25a. DATE REC'D. BY REGISTRAR
JAN 5 1987 | | |
| 25b. REGISTRAR'S SIGNATURE | | | | | | |

BP

[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "I", "W", "C", "D", "A", "L", "I", "E" are visible in the left margin.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove page 1 and 2 and return them to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body. Page 1 should be filed within 72 hours after death. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|---|--|--|--|---|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | 2b. HOUR A M |
| MILDRED | | | STEWART | | | 12-8-86 | | | 4:15 A |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR MONTHS DAYS | |
| Female | | Black | | 1 7 14 | | 72 YRS | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| North Carolina | | U.S.A. | | | | Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Baltimore | | Liberty Medical Center | | | | N/A | | N/A | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | 13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13c. STREET ADDRESS / ZIP CODE | | |
| 13a. STATE CITY OR TOWN | | | | | | | 18 Jackson Avenue 21061 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | |
| Anne Arundel Glen Burnie | | | | | Daisy Davis | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | |
| NO | | | 717-07-7530 | | Mary Singletary 7505 Woodhaven Ct | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASPIRATION PNEUMONIA</u> | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>SEPSIS</u> | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>DIARRHEA</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | |
| | | | P.M. 19 | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11-21-1986</u> to <u>12-8-1986</u> , that (I) (we) last saw the deceased alive on <u>12-8-1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | DEGREE | | | 22c. DATE SIGNED | | | |
| Anil Raiker | | | MD | | | 12-8-86 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22e. ADDRESS | | | | | | |
| ANIL RAIKER | | | LIBERTY MEDICAL CENTER | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | |
| BURIAL | | | 11/11/86 | | ARBUS CEMETARY | | Glen Burnie MD. | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| Leroy O. Dyett & Son 4600 Liberty Hqts Ave. | | | | | DEC 10 1986 | | Julia Raiker | | |

BP

026181 DEC -5 86

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|--|--|---|--|---|--|--|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Madelyn T. Stone | | | 2a. DATE OF DEATH
MONTH 12 DAY 2 YEAR 86 | | | 2b. HOUR
9:30 a. M. | | | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH 11 DAY 10 YEAR 1900 | | 6. AGE (IN YEARS LAST BIRTHDAY)
86 YRS. | | 7. IF UNDER 1 YEAR
MONTHS 0 DAYS 0 | | 8. IF UNDER 24 HRS.
HOURS 0 MIN. 0 | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
Maryland Somerset County | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Balto. City | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Church Home | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
Own Home | | | |
| 13a. STATE
Maryland | | | 13b. COUNTY
Balto. | | 13c. CITY OR TOWN
Balto. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
101 North Bond St., Balto., 21231 | | |
| 14. FATHER'S NAME
FIRST Alfred MIDDLE Tull LAST Tull | | | | 15. MOTHER'S MAIDEN NAME
FIRST Stella MIDDLE K. LAST Tull | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO.
219 32 4413 | | 17. INFORMANT
ADDRESS
Elizabeth Lutz, Balto., MD | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CVA
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost }
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I (this hospital) attended the deceased from 6/22 , 19 84 , to 12/2 , 19 86 , that (I (we) saw the deceased alive on 12/9 , 19 86 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I (we) did (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<i>Corazon Soares</i> | | | DEGREE
M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
12-2-86 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Corazon Soares | | | 22e. ADDRESS
101 North Bond St., Balto., Md. 21231 | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
12/5/86 | | 23c. NAME OF CEMETERY OR CREMATORY
Druid Ridge | | | 23d. LOCATION
CITY OR TOWN Pikesville, COUNTY MD STATE | | | |
| 24. FUNERAL DIRECTOR
NAME Henry W. Jenkins & Sons Co. ADDRESS 4905 York Road Balto., MD 21212 | | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 4 1986 | | 25b. REGISTRAR'S SIGNATURE
<i>Lia T. ...</i> | | | |

MEDICAL CERTIFICATION

29

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed and filed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of such.

BP. _____

INDEX

From Honorable

Tull

210 02 4410 Elizabeth, Mrs., Baltimore, Md.

N

x

NOTE: For Baltimore, Md., 2110
Henry W. Johnson & Son Co.
Baltimore, Md.
Sister, Mrs. F. J. Jones
Sister, Mrs. J. J. Jones

026593

FOR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | |
|---|--|---|---|---|---------------------------|--|
| 1. DECEASED NAME
FIRST MIDDLE LAST
HELEN L. STRUVEN | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12-7-86 | | 2b. HOUR
542 PM | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
NOVEMBER 12, 1909 | | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
77 YRS | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. IF UNDER 1 YEAR IF UNDER 24 HRS
MONTHS DAYS HOURS MIN. | | |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
NEW JERSEY | | 10. CITIZEN OF WHAT COUNTRY?
USA | | 11. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | |
| 12. CITY OR TOWN OF DEATH
BALTIMORE | | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNION MEMORIAL HOSPITAL | | 14. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
PROF. ARTIST | | |
| 15. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
15a. STATE
MO | | 15b. COUNTY
HARFORD | | 15c. CITY OR TOWN
DARLINGTON | | |
| 16. FATHER'S NAME
FIRST MIDDLE LAST
HENRY MAXWELL LUMMIS | | 17. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ETHEL FLORENCE HOWE | | 18. STREET ADDRESS / ZIP CODE
4303 CONOWINGO ROAD 21034 | | |
| 19. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 20. SOCIAL SECURITY NO.
266 48 8737 | | 21. INFORMANT
ADDRESS
MISS DIANA L. STRUVEN 9469 CATFEET CT., COLUMBIA, MO 21045 | | |
| 22. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) <u>respiratory arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) <u>pleural effusion</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<u>Alzheimer's, diabetes, hypoglycemia, Urinary tract infection, chronic anemia, decubitus ulcers</u> | | | | | | |
| 23a. DATE OF OPERATION | | 23b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 23c. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 24a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 24b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 24c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 25a. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 25b. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 25c. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 26. I certify that (I) (this hospital) attended the deceased from <u>11-24</u> , 19 <u>86</u> , to <u>12-7</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>12-7</u> , 19 <u>86</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. | | | | | | |
| 27a. SIGNATURE
L. Olding MD | | 27b. DEGREE
MD | | 27c. DATE SIGNED
12-7-86 | | |
| 28a. PHYSICIAN'S NAME (TYPE OR PRINT)
L. OLDING | | 28b. ADDRESS
UNION MEMORIAL HOSPITAL | | | | |
| 29a. BURIAL, CREMATION, REMOVAL (SPECIFY)
CREMATION | | 29b. DATE
8 DECEMBER 86 | | 29c. NAME OF CEMETERY OR CREMATORY
R. A. FERRIC + CO. | | |
| 29d. LOCATION
CITY OR TOWN COUNTY STATE
WEST CHESTER, PA. | | 30. FUNERAL DIRECTOR
NAME ADDRESS
MITCHELL FUNERAL HOME PA, HAVRE de GRACE, MD. 21078 | | | | |
| 31. DATE REC'D. BY REGISTRAR
DEC 9 1986 | | 32. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, the medical examiner will be notified at once.

03 01 20 00 10 00



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove and file pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|---|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | |
| DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
Willie J. Stuart | | | | 12 27 86 | | | |
| 3. SEX
male | | 4. RACE
Black | | 5. DATE OF BIRTH MONTH DAY YEAR
9 12 26 | | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS
60 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
S. C. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
2609 Woodland Avenue | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Disabled | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Md | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
James | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Minnie Lockhart | | 13e. STREET ADDRESS
2609 Woodland Ave | | 21215 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
Yes | | 16b. SOCIAL SECURITY NO.
245-28 5529 | | 17. INFORMANT ADDRESS
Jannie Garland 2734 Ashland Avenue | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) hypercalcemia
DUE TO, OR AS A CONSEQUENCE OF (b) Cancer of the lung
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/9 19 85, to 12 19 86, that (I) (we) last saw the deceased alive on 11/12 19 86, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
A. Calkins MD | | | | DEGREE | | 22c. DATE SIGNED
12/30/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
CALKINS | | | | 22e. ADDRESS
Radiation Oncology, J H H
600 N. Wolfe St, Baltimore MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
1/3/87 | | 23c. NAME OF CEMETERY OR CREMATORY
Eastview Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Baltimore MD | |
| 24. FUNERAL DIRECTOR NAME
March Funeral Home 1101 E. North Ave | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 2 1987 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Pandey | |

100-100000

ofh.